

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|--|--|--|---|--|---|--|
| 11883 | | 11892 | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| Ida L Acuff | | | | | | Aug., 4 1968 | | | 1.15AM |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| Female | White | | 20 Sept., 1890 | | | 77 | | YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Tenn. | | USA | | | | Pr. Geo., Md | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | | Pr., Geo. Gen., Hosp., | | | NONE | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | Pr. Geo., | | | Forestville | | 3115 Oak Glen Way | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Robert E. Lucas | | | Martha Detzell | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (Daughter) Address | | | |
| Unknown | | | Unknown | | | Lucille Duvall, 3115 Oak Glenn Way, Forestville, Md | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete Heart Block</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Intense atherosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>8-1-68</u> , to <u>8-4-68</u> , that (I) (we) last saw the deceased alive on <u>8-3-68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Oliver B. Bond</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>8-4-68</u> | | |
| 22d. PHYSICIAN'S NAME (Type) <u>OLIVER B. BOND MD</u> | | | | | 22e. ADDRESS <u>6872 RIVERDALE ROAD LANHAM MD 20801</u> | | | | |
| 23a. BURIAL, CREMATION, or other disposition (city) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 8-7-68 | | Arlington Nat'l Cemetery | | Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u> ADDRESS <u>4308 Suitland Rd. Suitland, Maryland</u> | | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 12 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u> | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11884

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11893

| | | | | | | | | | | | |
|---|--|--|---|---|--|---|--|---|-----|--|--|
| 1. DECEASED-NAME (Type or Print) First Middle Last Kate A Alston | | | 2a. DATE KNOWN OF DEATH Month Day Year <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 8-10-68 19 2:15am | | | 2b. HOUR 2:15am | | | | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH 1 June 1915 | | 6. AGE (In years last birthday) 53 YRS. | | 7c. DATE PRONOUNCED DEAD Month Day Year 8 10 68 19 2:30am | | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's | | | Md. | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b. COUNTY Prince George's | | 13c. CITY OR TOWN Chapel Oaks | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1221 58th. Avenue | |
| 14. FATHER'S NAME First Middle Last Jack Claytor | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Eliza Kent | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT ADDRESS George Alston-1221 58th Avenue | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 1538 DUE TO, OR AS A CONSEQUENCE OF Carcinoma of colon Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe MD | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED 8-12-68 | | | |
| EXAMINER'S NAME (Type) John Kehoe MD | | | | ADDRESS (Street, city, town, or county) Riverdale, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 8/14/68 | | 23c. NAME OF CEMETERY OR CREMATORY Caryer Memorial Park | | | | 23d. LOCATION (City or Town) (County) (State) Maryland | |
| 24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd. N. | | | | | | 25a. REC'D BY REGISTRAR AUG 14 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

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| | | | | | | | | | | | |
|--|--|---------|--|--|--|--|--|---|--|---|--|
| <div>11883</div> <div>Item 23 - Items 5</div> <div>11894</div> | | | | | | | | | | | |
| <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | | | | First | | Middle | | Last | |
| Raymond Daniel Armstrong Jr. | | | | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | | 8. IF UNDER 24 HRS. | |
| Male | | White | | 3-26-1942 | | 26 YRS. | | MONTHS | | DAYS | |
| | | | | | | | | HOURS | | MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Ill. | | | | U. S. A. | | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Prince George's Md | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | |
| Cheverly | | | | Prince George Hospital | | | | Custodian at Apartment Building | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | | | | | Montgomery Pr. Geo. Rockville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 9004 Riggs Road | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Raymond D. Armstrong, Sr. | | | | | | Amola | | | | Coats | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| Yes | | | | | | 1960 to 1961 356-43-8546 | | Father | | 3 Louis Rd., Joliet, Ill. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain | | | | | | | | | | | |
| 8160 DUE TO, OR AS A CONSEQUENCE OF Multiple skull fractures | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 2234 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in brief) | | | |
| | | | | | | 12:20am 8-5-1968 | | Driver of car which ran off road and struck | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | Ardmore Ardwick Road, Prince George County, Maryland | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural Causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md. | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 8-6-68 | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | | | 8-10-68 | | Versailles Cem. | | | | Versailles, Ill. | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| F. Gasch's Sons 4739 Balt. Ave, Hyattsville, Md | | | | | | AUG 8 1968 | | Charles Judge | | | |

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

100-100000

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
DATE: [Illegible]
[Illegible text follows]

Enclosure of [Illegible]
[Illegible text]

[Illegible text follows]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR A M | | |
| Lillian D. Arnold | | | | | | August 20 1968 | | 4:30 M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR MONTHS DAYS | | |
| Female | | White | | 9/3/95 | | 72 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Texas | | USA | | | | Prince George's Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Riverdale | | | E. Leland Memorial Hospital | | | Retired agent | | Railroad | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Pr. Geo. | | Riverdale | | YES | | 5703 Longfellow St. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Broadie A. Duke | | | Mary Hunt | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| no | | | | | E. Leland Mem. Hosp. 4408 Queensbury Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 ACUTE MYOCARDIAL INFARCTION | | | | | | | | 10 DAYS | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 DIABETES MELLITUS | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-12, 1968, to 8-20, 1968, that (I) (we) last saw the deceased alive on 8-20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Carl J. Houmann DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 8-21-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Carl J. Houmann, M.D. | | | | | 22e. ADDRESS 4408 Queensbury Rd. Riverdale, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug 23, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Stroud Cemetery | | 23d. LOCATION (City or Town) (County) (State) Stroud Lincoln Oklahoma | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS F. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DATE AUG 23 1968 | | 25b. REGISTRAR'S SIGNATURE | | |
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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|---------|--|--|---|----------------------------------|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 11887 | | | 11896 | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| FRANCES H. AULISIO | | | | | | 8 Month 18 Day Year 68 | | | 8:55 AM |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| 2 | White | | 5-20-18 | | | 50 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Pennsylvania | | U S A | | | | PRINCE GEORGES Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 74 CHEVERLY, Md. | | | PRINCE GEORGE'S GEN HOSP | | | HOUSEWIFE | | Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| 16 md. | | | P.G. | | GREENBELT | | | | 36 R. RIDGE Rd. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Joseph Ambrose | | | Veronica Cott | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| no | | | 170 10 7796 | | Calvin G. Aulisi0 Greenbelt, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intestinal Obstruction</u> 1830 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of the Left Ovary</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1750 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 17 Aug 68 | | Intestinal Obstruction | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) person attended the deceased from 1966 , to <u>Aug. 18, 1968</u> , that (I) was last saw the deceased alive on <u>Aug. 18, 1968</u> , and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) was (did) look view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22d. DATE SIGNED | | | |
| Arthur Kaufman M D | | | | | | 18 Aug 68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Arthur Kaufman M D | | Professional Bldg Centerway Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Aug 21, 1968 | | Gate of Heaven Cemetery | | Wheaton Montgomery, Md. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| F. Gasch's Sons | | Hyattsville, Md. | | DATE AUG 22 1968 | | Charles Judge | | | |

Police Internal Information

Continuation of the last page

17 Aug 68

Investigative Information

17A

17B

17C

17D

17E

17F

17G

17H

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11888

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|--|----------------------|--|-----------------------------------|---|---|--|--------------------------------|
| 1. DECEASED NAME (Type or print) Emma | | First | Middle J. | Last Bainum | 2a. DATE OF DEATH Month 8 Day 17 Year 1968 | | 2b. HOUR 1:58 P.M. |
| 3. SEX female | 4. RACE Caucasian | | 5. DATE OF BIRTH April 6, 1889 | | 6. AGE (In years last birthday) 79 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign country) Ohio | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md. | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Frederick | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME First Edward Middle Leisure Last | | 15. MOTHER'S MAIDEN NAME First Mary Middle Davis Last | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no | | | |
| 16b. SOCIAL SECURITY NO yes | | 17. INFORMANT Mr. Stewart Bainum 705 Edgewood Drive Silver Spring, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Ventricular Fibrillation 411.9 DUE TO, OR AS A CONSEQUENCE OF Cong. Heart Failure (b) 1-2 yr. DUE TO, OR AS A CONSEQUENCE OF Coronary Insuff. 10-20 yr. (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Generalized arteriosclerosis calcification | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-15, 1968, to 8-17, 1968, that (I) (we) last saw the deceased alive on 8-12, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE R. H. Sandstrom MD | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 8-7-68 | |
| 22d. PHYSICIAN'S NAME (Type) R. H. Sandstrom MD. | | 22e. ADDRESS 7701 Carroll Ave Tr Pk Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug. 19, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY St. Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Prince George Co., Maryland | |
| 24. FUNERAL DIRECTOR Warner E. Pumphrey, Inc. | | 8434 Georgia Avenue Silver Spring, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 21 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

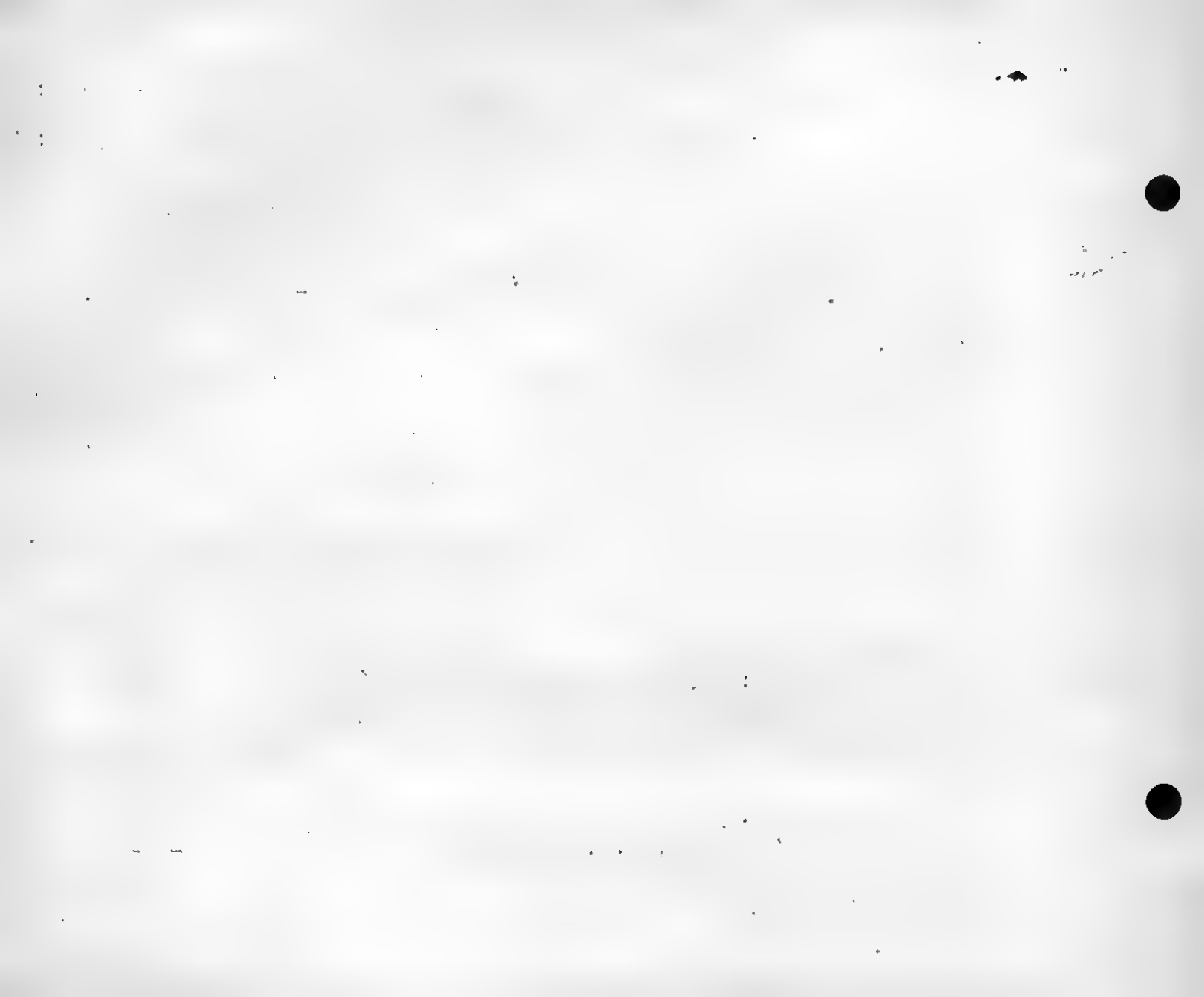
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11883

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

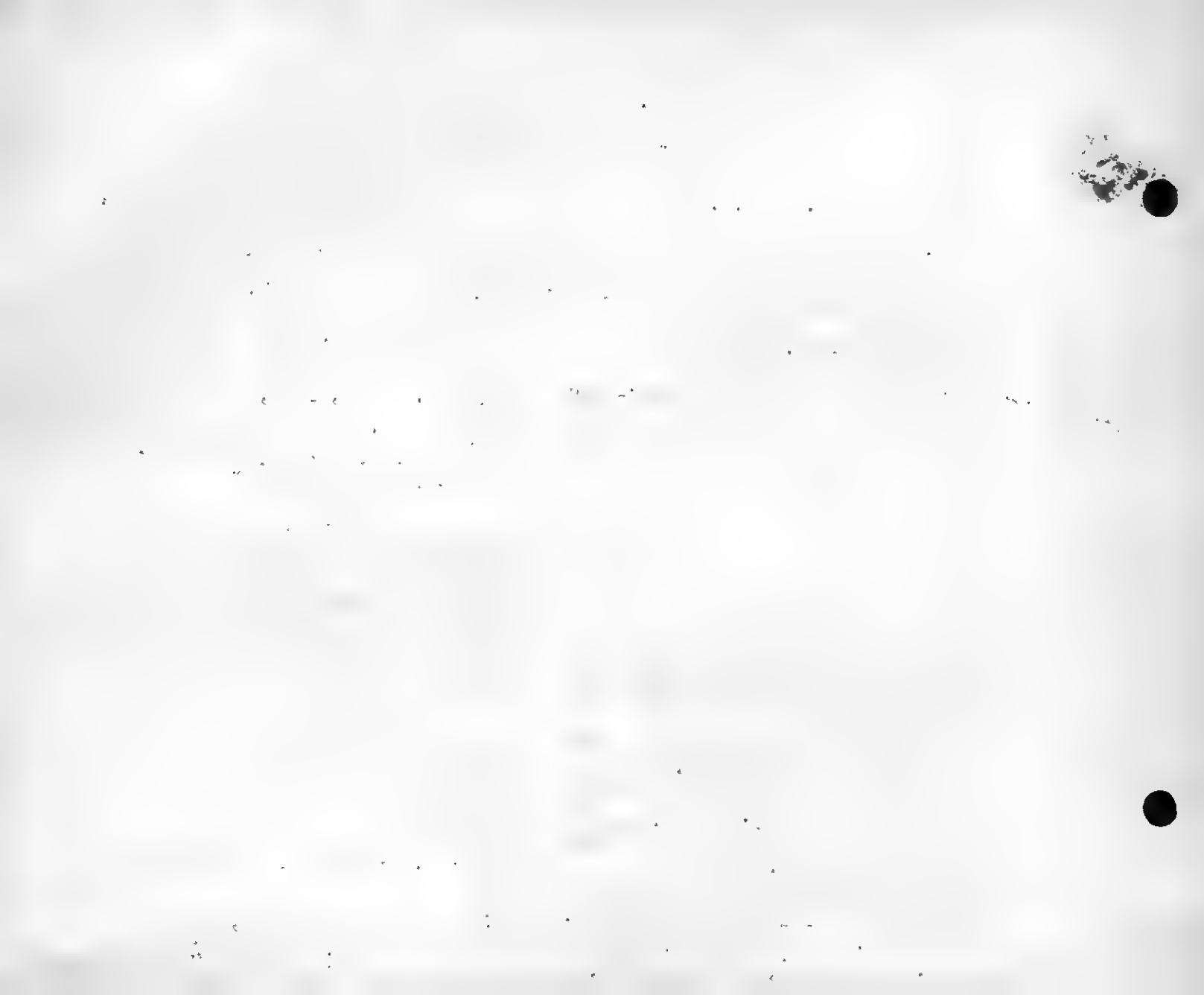
| | | | | | | | | | | | | | |
|---|--------|-----------------|-----------------------|--|--|-----------------------------|--|---|-------------------------|--|--|--|--|
| 1 DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | | 2b DATE PRONOUNCED DEAD | | | | |
| Charles D Barkley | | | | | | 8 22 1968 | | | 8 22 1968 | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (last birthday) | 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| M | W | 3 July 1888 | 80 YRS | PENNA | | U.S | | | | Prince George Md | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Riverdale | | | | Leland Hosp | | | | CABINET MAKER | | | | FURNITURE | |
| 13a USUAL RESIDENCE (Where deceased admission) STATE | | | | 13b COUNTY | | | | 13c STREET AND NUMBER | | | | | |
| Md. | | | | Prince George | | | | 9-A Hillside Rd. | | | | | |
| 14 FATHER'S NAME | | | | 15 MOTHER'S M A D E N NAME | | | | | | | | | |
| WINFIELD L. BARKLEY | | | | KATIE YOWLER | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b SOCIAL SECURITY NO | | | | 17 INFORMANT | | | | ADDRESS | |
| NO | | | | 175 40987A | | | | WARREN C. BARKLEY | | | | 147 N. POTOMAC ST HAGERSTOWN, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral atherosclerosis | | | | | | | | | | yrs. | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) and Subdural hematoma | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) from Trauma | | | | | | | | | | 24 hrs. | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month Day Year | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | |
| | | | | 1:30 am 8 21 68 | | | | Fell down steps | | | | | |
| 21d INJURY OCCURRED | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | Home | | | | Home of deceased | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | | 22b DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | | John Kehoe, M.D. Riverdale | | | | 8-22-68 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b DATE | | | | 23c NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION (City or Town) (County) (State) | |
| BURIAL | | | | 8-24-1968 | | | | FORT LINCOLN CEM | | | | COLMAR MANOR MD | |
| 24 FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a REC'D BY REG STRAR | | | | 25b. REGISTRAR'S SIGNATURE | |
| W.W. Chambers Co | | | | Riverdale Md | | | | DATE AUG 28 1968 | | | | James J. Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

| 11890 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 11099 | | | |
|---|--|--|---|--|--|---|--|--|---|---|--|-----------------------------|--|--|---------------------------|--|--|--|--|---|--|--|--|
| 1 DECEASED NAME (Type or print) First Middle Last | | | | | | | | | | 2a DATE OF DEATH Month Day Year | | | | | | | | | | 2b HOUR | | | |
| William J. Bayne | | | | | | | | | | 8/2/68 | | | | | | | | | | 10:45 AM | | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (In years lost birthday) | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS HOURS MIN | | | | | | | | |
| Male | | | Caucasian | | | 9/23/20 | | | 47 YRS. | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH | | | | | | | | | | | | | | |
| Washington, D.C. | | | U.S.A. | | | | | | Prince Georges County, Md | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Clinton, Maryland | | | Clinton Community Hospital | | | Mgmt. Tech. | | | Andrews AFB | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b. COUNTY | | | 13c CITY OR TOWN | | | 3d. INSIDE CITY "A" YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER | | | | | | | | | | | |
| Maryland | | | Prince Geo. | | | Tem le Hills | | | | | | 5622 Fisher Rd. | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | |
| Richard S. Bayne | | | Fannie Cauffman | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17 INFORMANT Address | | | | | | | | | | | | | | | | | |
| Yes | | | 578-09-8138 | | | Madelyne K. Bayne, wife, Same as # 13 | | | | | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) EXSANGUINATION, ESOPHAGEAL HEMORRHAGE | | | | | | | | | | 5 MIN. | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CARCINOMA OF NECK | | | | | | | | | | > 2 mos | | | | | | | | | | | | | |
| (c) THOROTRAST INJECTION | | | | | | | | | | > 10 years | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medico examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 6/27, 19 68, to 8/2/68, 19, that (I) (we) last saw the deceased alive on 8/2/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) [did] (did not) view the body after death | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Robert W. Merkle</i> | | | | | | | | | | 22c. DATE SIGNED 8/2/68 | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Robert W. Merkle | | | | | | | | | | 22e. ADDRESS 116 McKendree Rd., Brandywine, Md. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE 8-6-68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Balt. National Cemetery | | 23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland | |
| 24 FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home | | | | | | | | | | 25a REC'D BY REGISTRAR AUG 12 1968 | | | | | | | | | | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |
| 4308 Suitland Road, Suitland, Maryland | | | | | | | | | | DATE | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 11891 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 11800 | |
| 1. DECEASED NAME (Type or print) First Middle Last Catherine C. Beatty | | | | | | 2a. DATE OF DEATH Month Day Year Aug. 22 1968 | |
| 3. SEX Female | | 4. RACE W | | 5. DATE OF BIRTH Month Day Year May 10, 1887 | | 6. AGE (In years last birthday) 81 YRS | |
| 7a. BIRTHPLACE (State or foreign country) Decatur, Ill. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md. | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyattsville Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution) STATE Pa. | | 13b. COUNTY Chester | | 13c. CITY OR TOWN Chester | | 13d. STREET AND NUMBER 717 Nilldale Rd. | |
| 14. FATHER'S NAME First Middle Last William Carroll | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Ellen Curran | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO (If yes give war or dates of service) 2-64-02-0026 | | 17. INFORMANT Address MRS. MARY E. HOPKINS, DAUGHTER, HYATTS MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> 1409 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), (b) <u>4 years</u> stating the underlying cause last. <u>4500</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Multiple sclerosis</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u> |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , 19____, to <u>8/22/68</u> , 19____, that (I) (we) last saw the deceased alive on <u>8/20/68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>William A. Wimsatt</u> | | | | 22c. DATE SIGNED <u>8/23/68</u> | | 22d. PHYSICIAN'S NAME (Type) William A. Wimsatt | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8-26-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington National | | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia | |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc., 5130 Wisc. Ave. N.W., Wash., D.C., 20016 | | | | 25a. REGD. BY REGISTRAR DATE AUG 26 1968 | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|----------------------------|--|--|--------------------------|--|--|--|--|----------|--|--|--|--|--|--|--|--|--|
| 11892 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 11901 | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) First Middle Last | | | | | | | | | | 2a. DATE OF DEATH Month Day Year | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| Boris Benes | | | | | | | | | | 22 Aug. 1968m | | | | | | | | | | 4 30AM | | | | | | | | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | | 7 UNDER 1 YEAR MONTHS DAYS | | | 8 UNDER 24 HRS HOURS MIN | | | | | | | | | | | | | | |
| Male | | | White | | | April 2, 1894 | | | 74 YRS. | | | | | | | | | | | | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | Md | | | | | | | | | | | | | | |
| RUSSIA | | | CUBA | | | | | | Prince Georges | | | | | | | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| Cheverly | | | Pr. Geo. Gen. Hosp | | | Indust. factory | | | textiles | | | | | | | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER | | | | | | | | | | | | | | | | | |
| NORTH CAROLINA | | | Hicklenburg | | | CHARLOTTE | | | | | | 458 Elmhart Rd - | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Elias Benes | | | Rebecca | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | | | | | | | | | | | | | | | | |
| | | | 265-72-0965 | | | Bernardo Benes | | | 1666 Bay Dr Miami Beach, Fla. | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute cardiac failure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS, A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) Hepatic coma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) Metastatic malignant melanoma | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1109 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | | | | |
| | | | 19 P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING ETC) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 1, 1965, to Aug 22, 1968, that (I) (we) last saw the deceased alive on Aug 21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | | 22c. PHYSICIAN'S NAME (Type) | | | 22d. ADDRESS | | | 22e. DATE SIGNED | | | | | | | | | | | | | | | | | | | | |
| | | | DR DAVID ANDERS | | | 3308 Dodge Park Rd Sandover Md | | | 8/22/68 | | | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | |
| (BURIAL) REMOVAL 8-23-68 | | | | | | MT. SINAI | | | MIAMI, FLORIDA | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | |
| SOL LEVINSON & BROS., | | | 6010 REISTERSTOWN ROAD | | | AUG 23 1968 | | | [Signature] | | | | | | | | | | | | | | | | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

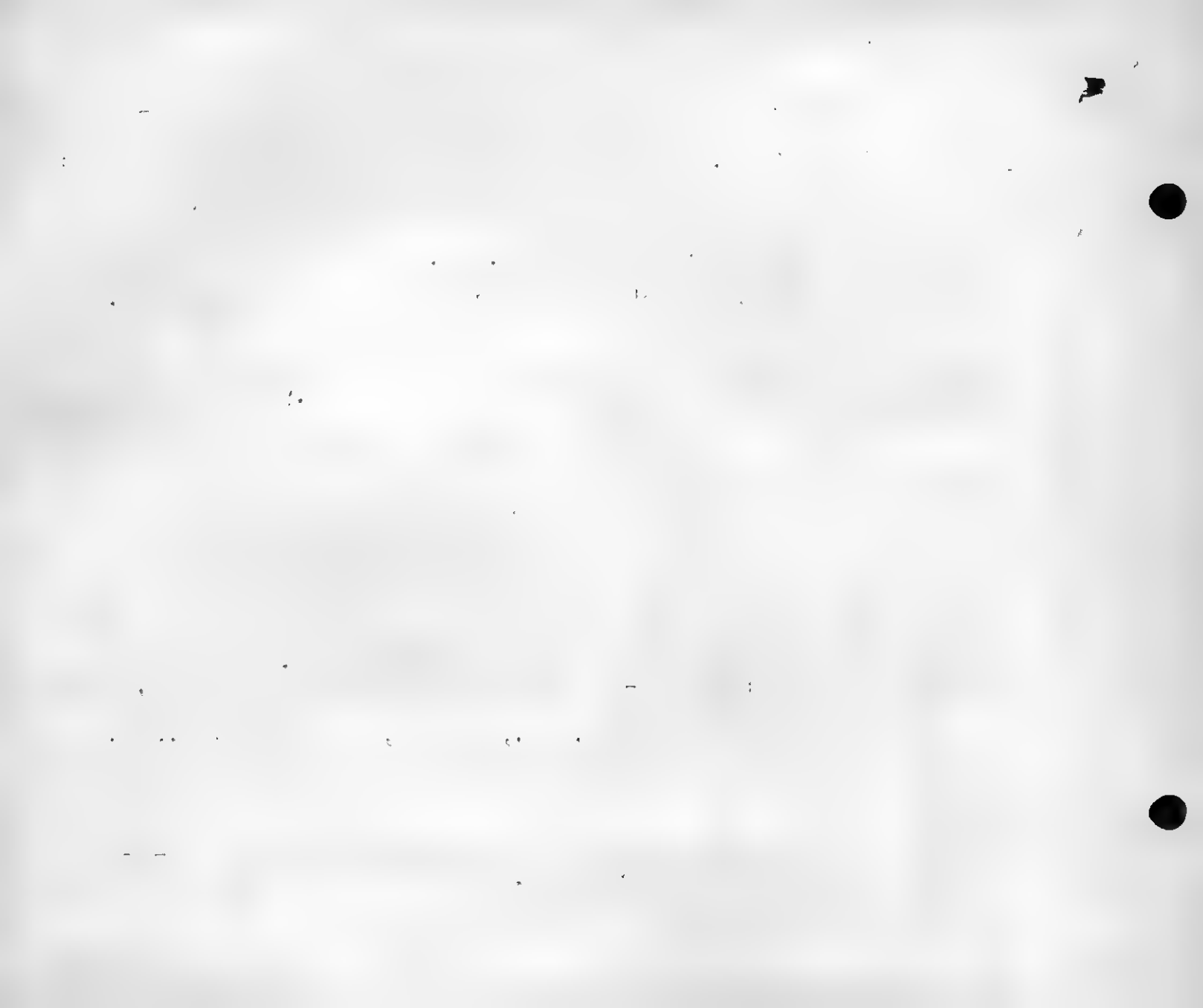
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11893

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11202

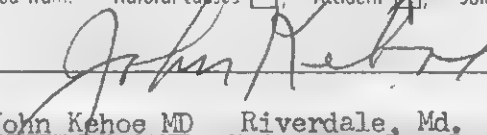

| | | | | | | | | | | | |
|---|--------|------------------------------|--|---|------------------------|---|--|--|---|--|--|
| 1 DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8-24-68 19 7:00am | | | 2b HOUR | | |
| Chester | | | J. Bialecki | | | | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | 7 UNDER YEAR MONTHS | 8 IF UNDER 24 HRS DAYS | 2c DATE PRONOUNCED DEAD | | | 2d HOUR | | |
| Male | White | 7 Aug. 1929 | 39 YRS | | | Month 8 Day 24 Year 68 19 11:00am | | | | | |
| 7a BIRTH-PLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md | | |
| PENN'A | | U.S | | | | Prince George's | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | In front of 3426 55th. Ave. | | | SALES MAN | | | POTOMAC CONSTR. Co | | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? | | |
| Maryland | | | Prince George's | | | Landover | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15 MOTHER'S M A DEN NAME | | | 13e STREET AND NUMBER | | | | | |
| First Middle Last | | | First Middle Last | | | 2500 Marlboro Ave. | | | | | |
| CHESTER. BIALECKI | | | ANNA. DOMZALSKI | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | ADDRESS | | |
| YES | | | KOREAN | | | UNKNOWN | | | ANNA. DOMZALSKI 56 Roscoe St. PITTSBURG, PENN'A. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute pulmonary congestion and edema</u> | | | | | | | | | | | |
| 913.7 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>Mechanical asphyxia (Face down in front seat of automobile)</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20 AUTOPSY? | | | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b TIME OF INJURY Month, Day, Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | 6:55am 8-24- 19 68 | | | Face down on car seat. Asphyxiated by occlusion of airway, collapsed | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | In front of 3426 55th. Ave., Cheverly, Prince George Co., Md. | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 8-26-68 | | |
| John Kehoe MD | | | Riverdale, Md. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | |
| BURIAL | | | AUG 29 1968 | | | ST. ADALBERT'S CEM | | | PITTSBURG PENN'A. | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a REC'D BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | |
| W. W. CHAMBERS CO. RIVERDALE, MARYLAND | | | | | | DATE SEP 3 1968 | | | Charles Judge | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|---------|------------------|--|--------------------------------|---|---|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | |
| Hassie Leon Bigelow | | | | | | Month Day Year | | 8-10-68 19 7:31pm | | |
| 3 SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD | | |
| Male | Negro | 5-17-1917 | 51 YRS | | | | | Month Day Year | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 2d. HOUR | |
| North Carolina | | | U.S.A. | | | | Prince George's | | 8 10 68 19 8:15pm M | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USIA. OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince George Hospital | | | Truck Driver | | Unk. | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution on admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| District of Columbia | | | Washington | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 207 6th. St., N.E. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| Albert | | | Chambers | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| | | | | | Hillcrest, Md. Elouise Bigelow - 5021 Chadwick Cr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Penetrating wound of left chest</u> DUE TO, OR AS A CONSEQUENCE OF <u>Gear shift lever of auto.</u> | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 8-12-68 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | 7:30pm 8-10-19 68 | | Passenger in car which struck a tree. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | 2400 block of Oxon Run Drive, Prince George County, Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | | |
|  | | | John Kehoe MD Riverdale, Md. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 8-12-68 | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 8-15-68 | | Harmony Memorial | | Prince George, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| John t. Rhines Co. Funeral Home 3015 12th Street, NE., Washington, D.C. | | | | | DATE AUG 16 1968 | |  | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11895

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | |
|--|--------|-----------------------------|---|--|--|--|--|---|--|--|--|--|
| 1 DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> 8 22 1968 | | | | 2b HOUR 1:00 | | |
| John S Bobel | | | | | | | | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c DATE PRONOUNCED DEAD Month 8 Day 22 Year 1968 | | | | 2d HOUR 7:40 AM |
| M | W | 8 Nov., 1910 | 57 YRS | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md | | | | | | |
| Illinois | | U S A | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp. | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Carpenter | | | 12b KIND OF BUSINESS OR INDUSTRY Construction | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Md. | | | 13b COUNTY Prince George | | | 13c CITY OR TOWN Bladensburg | | | 13d INSIDE CITY J.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER 4113 51st St. |
| 14. FATHER'S NAME Peter Bobel | | | 15 MOTHER'S MAIDEN NAME Marciaann Neton | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | 16b SOCIAL SECURITY NO 271 05 3396 | | | 17 INFORMANT Ann Bobel | | | ADDRESS Bladensburg, Md. | | | |
| 16c (If yes give year or dates of service) W W 11 | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 4121 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Associated with cirrhosis of liver.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes unknown | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200 | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No | | | City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D., Riverdale | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 8-22-68 | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b DATE Aug 26, 1968 | | | 23c NAME OF CEMETERY OR CREMATORY Baltimore National | | | 23d LOCATION (City or Town) (County) (State) Baltimore, Md. | | | |
| 24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | | | | | 25a REC'D BY REGISTRAR DATE AUG 26 1968 | | | 25b REGISTRAR'S SIGNATURE | | | |

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the body. PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11896

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11905

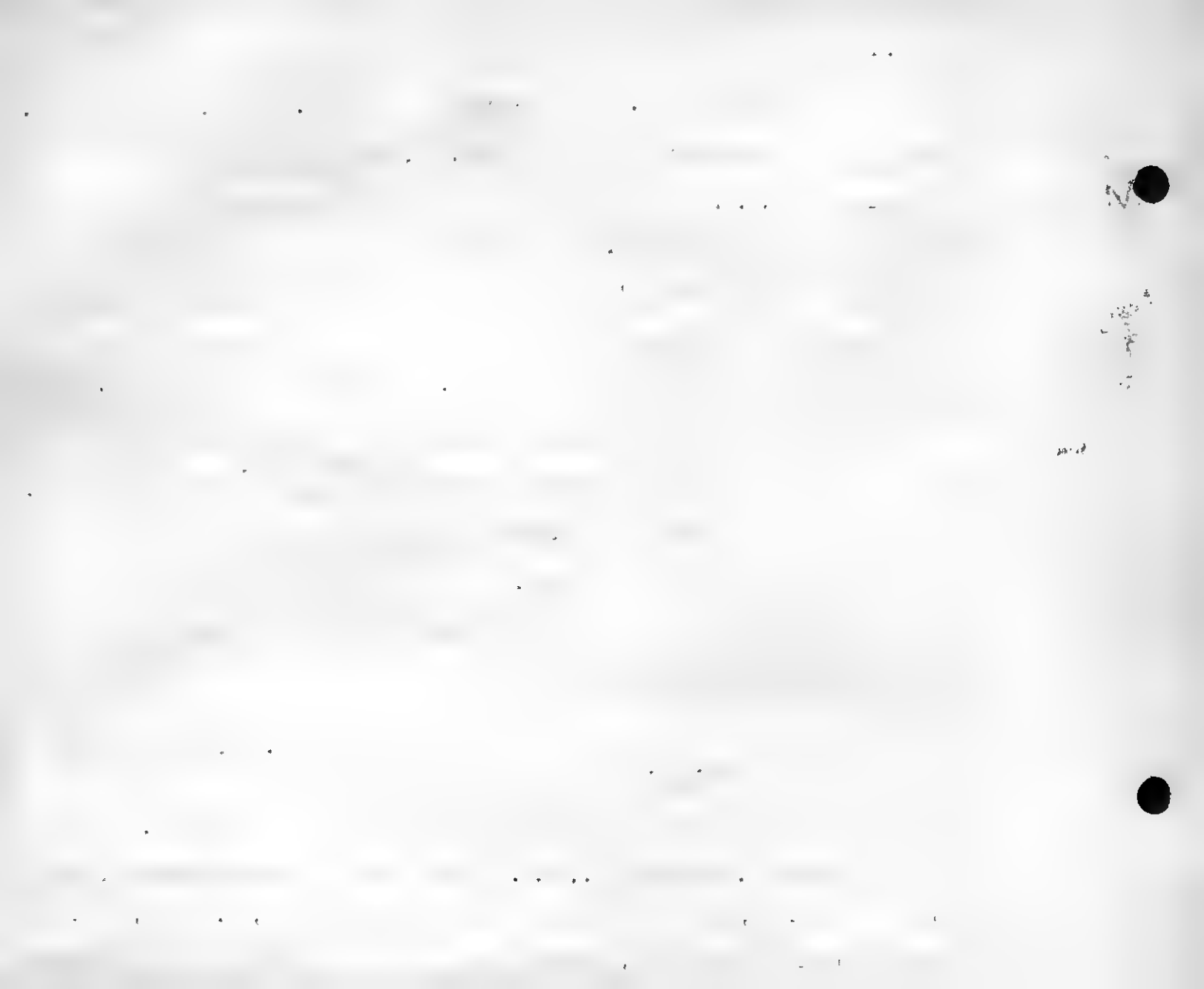
| | | | | | | | |
|---|--------|---|-----------------------------------|---|---|---|--|
| 1 DECEASED NAME (Type or Print) | | First | Middle | Last | 2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | 2b HOUR 4:45 P.M. |
| Brenda | | Jean | | Bodenhamer | | 8 22 1968 | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | 7 UNDER YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d HOUR 4:45 P.M. |
| F. | W. | 17 Mar., 1962 | 6 YRS. | | | 8 Day 22 Year 1968 | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| | | U.S. | | | | Prince George Md | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a USUAL OCCUPATION (Kind of work done during most of work life even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Riverdale | | Leland Hosp | | 2nd ment. | | none. | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md | | Prince George | | Beltsville | | 4926 Naples Ave., | |
| 14 FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First Middle Last |
| PAUL | | F. | BODENHAMER | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| | | | | PAUL BODENHAMER | | 4926 NAPLES AVE BELTSVILLE, MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing injury to chest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 55 min. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1120 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. 3:50 P.M. | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Run over by truck wheel | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 4900 Block Naple Ave. | | 21f. LOCATION Street or R.F.D. No City or Town County State Beltsville Prince George Md. | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | John Kehoe, M.D., Riverdale | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b DATE SIGNED 8-22-68 |
| EXAMINER'S NAME (Type) | | | | | ADDRESS (Street, city, town, or county) | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | Aug. 26, 1968 | | St. Johns Episcopal Church Cem | | Beltsville, P. Georges. Md | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REG STRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John J. Starks | | 550 WASH BLDG | | DATE AUG 26 1968 | | John J. Starks | |

1500 + 2000 2000 2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

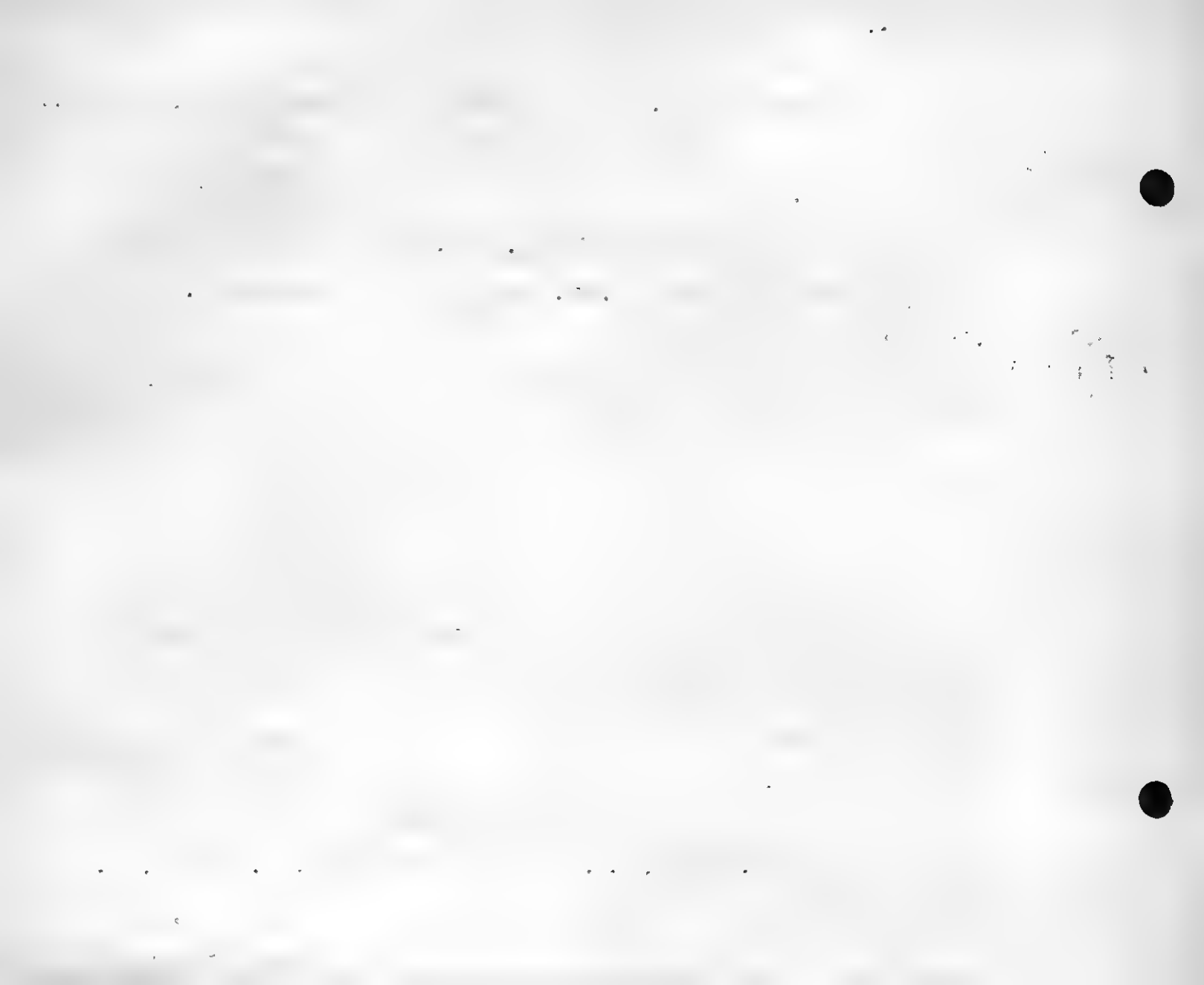
| | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|---|---|---|--|---|--|--|--|---|---|--|-----------------------------------|--|--|--|--|----------------------------|--|
| 11897 | | | | | | | | | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 6 Film 304 871728-1 | | | | | | | | | | 806 | |
| 1 DECEASED-NAME (Type or print) First Middle Last Mary B. Bowles | | | | | | | | | | 2a. DATE OF DEATH Month Day Year Aug. 28, 1968 | | | | | | | | | | 2b. HOUR 3 P. M. | |
| 3. SEX Female | | | 4. RACE Caucasian | | | 5. DATE OF BIRTH Oct. 12, 1906 | | | 6. AGE (In years last birthday) 61 67 YRS. | | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS. HOURS MIN | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Prince George's Md | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Maryland | | | | | 13b. CITY OR TOWN Glendale | | | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER 4706 Temple Hill Road | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last GEORGE KNOTT | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last IDA BARBER | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | | | 16b. SOCIAL SECURITY NO | | | | | 17. INFORMANT Address ERNEST C. BOWLES 4706 TEMPLE HILL RD. GLENDALE MARYLAND | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction due to strangulation of terminal ileum. DUE TO, OR AS A CONSEQUENCE OF (b) Marked intestinal adhesions, secondary to abdominal surgeries. DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) Emphysema, severe. | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION 16 Aug 68 | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Adipose tissue resection | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from July 18, 1968 to Aug. 28, 1968 , that it (we) last saw the deceased alive on Aug. 28, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. He (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE George S. Banning, Jr., M.D. | | | | | | | | | | 22c. DATE SIGNED Aug. 29, 1968 | | | 22d. PHYSICIAN'S NAME (Type) George S. Banning, Jr., M.D. | | | | | | | | |
| 23a. BURIAL CREMATION, (Specify) BURIAL | | | | 23b. DATE Aug. 31, 1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY SACRED HEART CEMETERY | | | | 23d. LOCATION (City or Town) (County) BUSHWOOD, ST. MARY'S, MARYLAND | | | | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS W. BLARKE MATTINGLEY LEONARDTOWN, MARYLAND 20650 | | | | | | | | 25a. REC'D BY REGISTRAR SEP 3 1968 | | | | 25b. REGISTRAR'S SIGNATURE James J. Jones | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|--|--|--|--|------------------------------------|---|---|---|--|--|---|-------------------------------|-------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | | |
| Frances | | | G. | | Bradley | | August | | 10 | | 1968 12:30AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years 61st birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | |
| Female | | White | | 1/18/02 | | | 66 | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. | | |
| Washington, DC | | | U.S.A. | | | | | Prince George's | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Cheverly | | | Prince George's Gen. Hosp. | | | Clerk | | | Private | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INS DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | | Prince Geo. | | | Mt. Rainier | | YES | | 4231 29th St. | | | |
| 14. FATHER'S NAME | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | |
| Michael | | | W. | | Pyne | | | | Agnes | | | Genson | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or (unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | 4231 29th Street | | | | |
| None | | | 578442312 | | | Mary Pransom, | | | Mt. Rainier, Maryland | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Obstructive Lung Disease</u> Condit ans, if any, which gave rise to immed ate cause (a), stating the under ying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 9 1968</u> , to <u>August 10 1968</u> , that (I) (we) saw the deceased alive on <u>Aug 9 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Benjamin S. Miller</u> | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>Aug 10 1968</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) Benjamin S. Miller, M.D. | | | | | 22e. ADDRESS 3824 34th Street, Mt. Rainier, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | 8/13/1968 | | Ft. Lincoln Cemetery | | | Colmar Manor, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Mt. Rainier, Md. | | | | | 25a. REC'D BY REGISTRAR DATE AUG 14 1968 | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11893

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 7a & 7b File 1008
CERTIFICATE OF DEATH

1008

| | | | | | | | | | | | |
|--|--|---|---------------------------------------|---|---|--|---|--|---|--|---------|
| 1 DECEASED-NAME (Type or print) JOSEPH | | | First | Middle | Last | 2a DATE OF DEATH Month August Day 3 Year 1968 | | | 2b HOUR 9P | | |
| 3. SEX MALE | | 4. RACE Caucasian | | 5. DATE OF BIRTH 3-21-83 | | | 6. AGE (In years last birthday) 85 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a BIRTHPLACE (State or foreign country) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH PRINCE GEORGES Md | | | | | |
| 10. CITY OR TOWN OF DEATH FORESTVILLE | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Regept Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Postmaster | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE MD. | | 13b. COUNTY Pr. Geo | | 13c. CITY OR TOWN Forestville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 2703 Shelton Pl. | | | |
| 14. FATHER'S NAME UNKNOWNED | | | First | Middle | Last | 15 MOTHER'S MAIDEN NAME UNKNOWNED | | | First | Middle | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown) | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT Nursing Home Records | | | Address |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASHD 4127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Multiple Decubitus ulcers | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 7/15 , 19 68 , to 8/3 , 19 68 , that (I) (we) last saw the deceased alive on 7/29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE John F. Shay MD | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 8-4-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) JOHN F. SHAY | | 22e. ADDRESS Switland, Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 8-5-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Green Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Pr. Geo, Md, Maryland | | | | | |
| 24. FUNERAL DIRECTOR Simmons Bros. | | ADDRESS 111-3d. Hope Rd. Pr. Geo. | | 25a. REC'D BY REGISTRAR AUG 6 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|----------------------------|--|--|
| Item 13 Film 0403 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Anna Brennen | | | | | | 2a. DATE OF DEATH Month Day Year August 3, 1968 | | | 2b. HOUR 4:46 PM | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH April 11, 1878 | | 6. AGE (In years last birthday) 90 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Illinois | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Prince George's Gen'l Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived if institution - Residence before admission) STATE Maryland | | 13b. COUNTY Prince George's | | 13c. CITY OR TOWN Forestville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 146 Clyde Avenue Regent Nursing Home | | | |
| 14. FATHER'S NAME First Middle Last O'Brien | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Not Known | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO ----- | | 17. INFORMANT Address Mrs. Bruce Brennan McLean, Va. | | | | | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal obstruction due to strangulation of terminal ileum. DUE TO, OR AS A CONSEQUENCE OF (b) Massive aspiration of gastric content, terminal. DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-8- , 1968 , to August 3, 1968 , that (I) was saw the deceased alive on August 3, 1968 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) (saw) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE Oliver B. Bond | | | | DEGREE M.D. | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 8-5-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Oliver Bond, M. D. | | | | 22e. ADDRESS 6872 Riverdale Rd., Lanham, Maryland 20801 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE August 8, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens | | 23d. LOCATION (City or Town) (County) (State) Washington Co. 12 | | | | | |
| 24. FUNERAL DIRECTOR Seals Funeral Home - Arlington, Va. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR AUG 9 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

[1.]

II

III



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|---|--|---------------------------------|---|---|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) | | | First Samuel Middle Eugene Last Brooks | | | 2a DATE KNOWN OF DEATH | | | 2b HOUR | | |
| 3 SEX M | | | 4 RACE Negro | | 5 DATE OF BIRTH 22 Sept 1959 | | 6 AGE (in years last birthday) 8 YRS | | 2c DATE PRONOUNCED DEAD Month 8 Day 21 Year 1968 | | |
| 7a BIRTHPLACE (State or foreign country) Md. | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Prince George Md. | | |
| 10 CITY OR TOWN OF DEATH Cheverly | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None | | | 12b KIND OF BUSINESS OR INDUSTRY None | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md. | | | 13b COUNTY Prince George Rural | | | 13c CITY OR TOWN Rt 197, Box 129 G | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14 FATHER'S NAME First Samuel E. Middle Brooks Last Brooks | | | 15 MOTHER'S MAIDEN NAME First Margaret Middle Thomas Last Thomas | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b SOCIAL SECURITY NO None | | |
| 17 INFORMANT Samuel E. Brooks | | | ADDRESS Samsens 13 E | | | 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Drowning 7100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1998 | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b TIME OF INJURY Month, Day, Year 8:45 PM 8 21 19 68 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fell off pier while fishing. | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Pond | | | 21f LOCATION Street or R.F.D. No Fox Recreation Area, Prince George Md. | | | City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D., Riverdale | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED 8-21-68 | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE 8-24-68 | | | 23c NAME OF CEMETERY OR CREMATORY Holy Family | | | 23d LOCATION (City or Town) (County) (State) Woodmore Md. | | |
| 24 FUNERAL DIRECTOR 145 Washington St 4925 Deane Ave NE | | | ADDRESS | | | 25a REC'D BY REGISTRAR DATE AUG 26 1968 | | | 25b REGISTRAR'S SIGNATURE Jesse Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

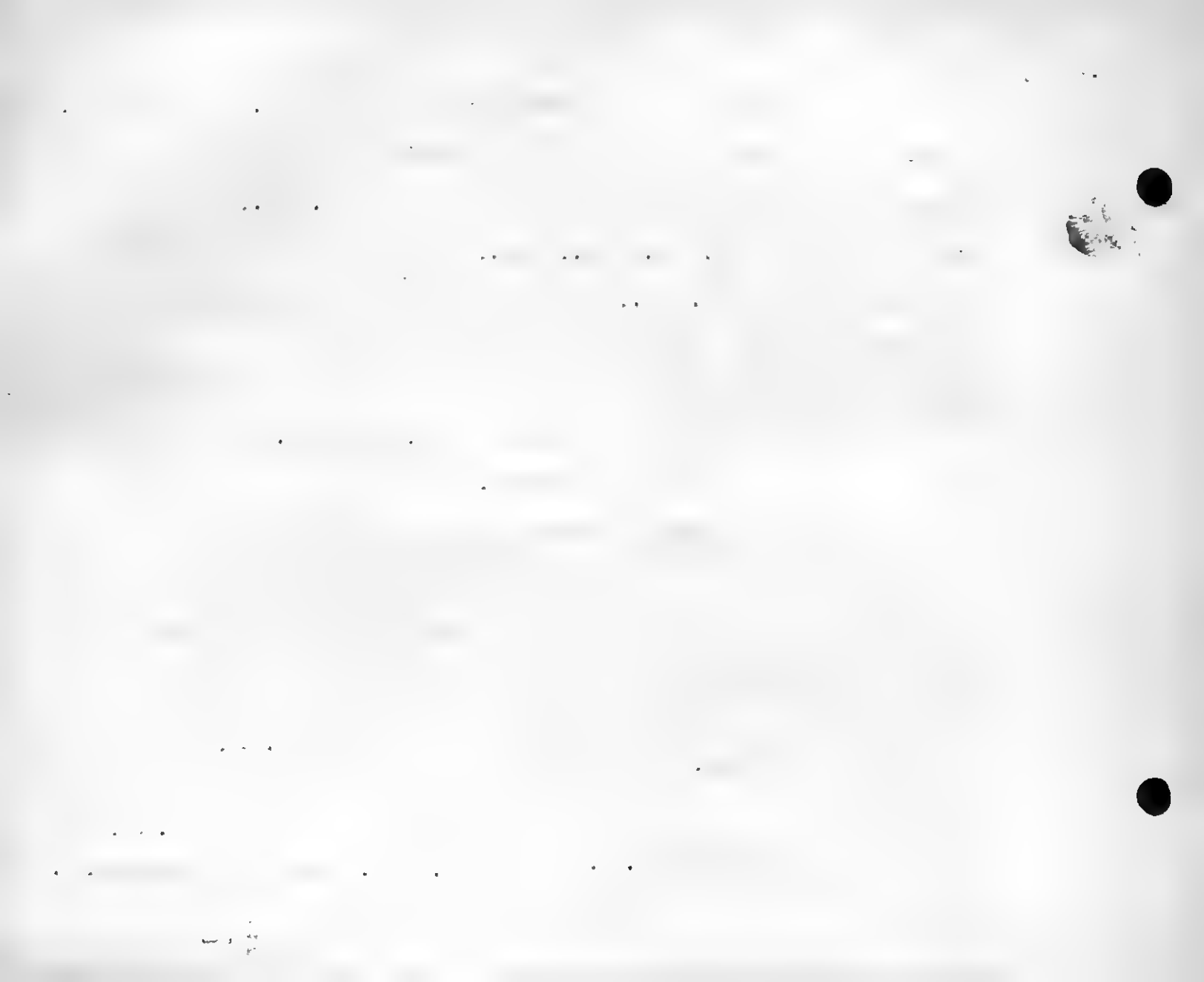
| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|---|--|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | |
| Baby Boy Brown | | | | | | Aug., 28 68 | | 1,30PM | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (in years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Male | | Negro | | 28 Aug., 1968 | | YRS. | | 3 | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Prince Georges Md | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cheverly | | Prince Georges General Hospital | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Pr. Geo. | | Chapel Oaks | | | | 1509 52nd Ave. N.E. | |
| 14 FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Thomas Brown | | | Hilda Callier | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | Address | | |
| | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity, severe. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Physical deformity, marked. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BJT. NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a I certify that (I) (last hospital) attended the deceased from Aug. 28, 1968 to Aug. 28, 1968, that (I) last saw the deceased alive on Aug. 28, 1968, and that in (my) work ^{work} supervision death occurred on the date and hour and from the causes stated above, (I) work ^{work} did (did not) view the body after death | | | | | | | | | |
| 22b. SIGNATURE <i>Henry A. Wise, Jr.</i> | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| | | | | | | | Aug. 29, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| Henry A. Wise, Jr. | | | | | 13008 9th St., Bowie, Md. 20715 | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| | | 9/21/68 | | Prince George's General Hospital | | Cheverly, Maryland | | | |
| 24 FUNERAL DIRECTOR <i>Henry A. Wise, Jr., Administrator</i> | | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | |
| | | | | | SEP 21 1968 | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|---------------------------------------|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| Russell Brown Jr | | | | | | Aug. 29 1968 | | | 4:15AM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| Male | | White | | 18 Sept 1933 | | 36 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| WASHINGTON D.C. | | U.S. | | | | Pr. Geo., Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | | Pr. Geo. Gen. Hosp. | | | LETTER CARRIER | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Pr. Geo. | | Greenbelt | | YES | | 19 C Pkwy |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | |
| RUSSELL LEE BROWN SR | | | | | | ETHEL E. BALL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | |
| NO | | | UNKNOWN | | RUSSELL LEE BROWN, SR | | 3903 METZ POTTER COLLEGE RD, MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral pulmonary emboli, recurrent. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Infarctions of lungs. | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Multiple sclerosis | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from _____, 19____, to Aug. 29, 1968, that (I) (we) saw the deceased alive on Aug. 29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Arthur Kaufman, M.D. | | | | | 22c. DATE SIGNED Aug. 29, 1968 | | 22d. ADDRESS Prof. Bldg., Centerway, Greenbelt, Md. | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| CREMATION | | AUG 31 1968 | | FORT LINCOLN CEM | | COLMAR MANOR, MD. | | | |
| 24. FUNERAL DIRECTOR W.W. CHAMBERS | | | | | 25a. REC'D BY REGISTRAR SEP 3 1968 | | 25b. REGISTRAR'S SIGNATURE James J. Jones | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with for Pages 1, 2, and 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11904

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11012

| | | | | | | | | | |
|--|---------|------------------------------|--|---|------|---|--|---|---|
| 1. DECEASED NAME (Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN OF DEATH EST. <input type="checkbox"/> Month Day Year MATED <input checked="" type="checkbox"/> 8-8-68 19 4:45pm | | | 2b. HOUR |
| Verna | | | G | Brown | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
| Female | White | 21 Dec. 1913 | 54 YRS | | | | | 8 8 68 19 4:53pm M | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md | | | |
| Alabama | | US A | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cheverly | | | Prince George Hospital | | | Char woman | | | Railroad co |
| 13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 3d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
| Maryland | | | Prince George's | | | Forestville | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 3114 Oak Glen Way |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| Almer | | | Green | | | Velie | | | Bell |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | ADDRESS |
| no | | | (If yes give war or dates of service) | | | 719 16 3901 | | | Charles P Brown Forestville, Md |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Liver failure</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>Cirrhosis of liver</u> | | | | | | | | | over 6 mo. |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) _____ | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | | | |
| (c) _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 5110 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| CAUSE OF DEATH | | | 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 8-9-68 | | | |
| John Kehoe MD | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| Riverdale, Md. | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) |
| Burial | | | Aug 12, 1968 | | | Ft Lincoln Cemetery | | | Colmar Manor Pro Geo Md |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. <i>John Charles Judge</i> |
| F. Gasch's Sons | | | Hyattsville, Md. | | | DATE AUG 12 1968 | | | |

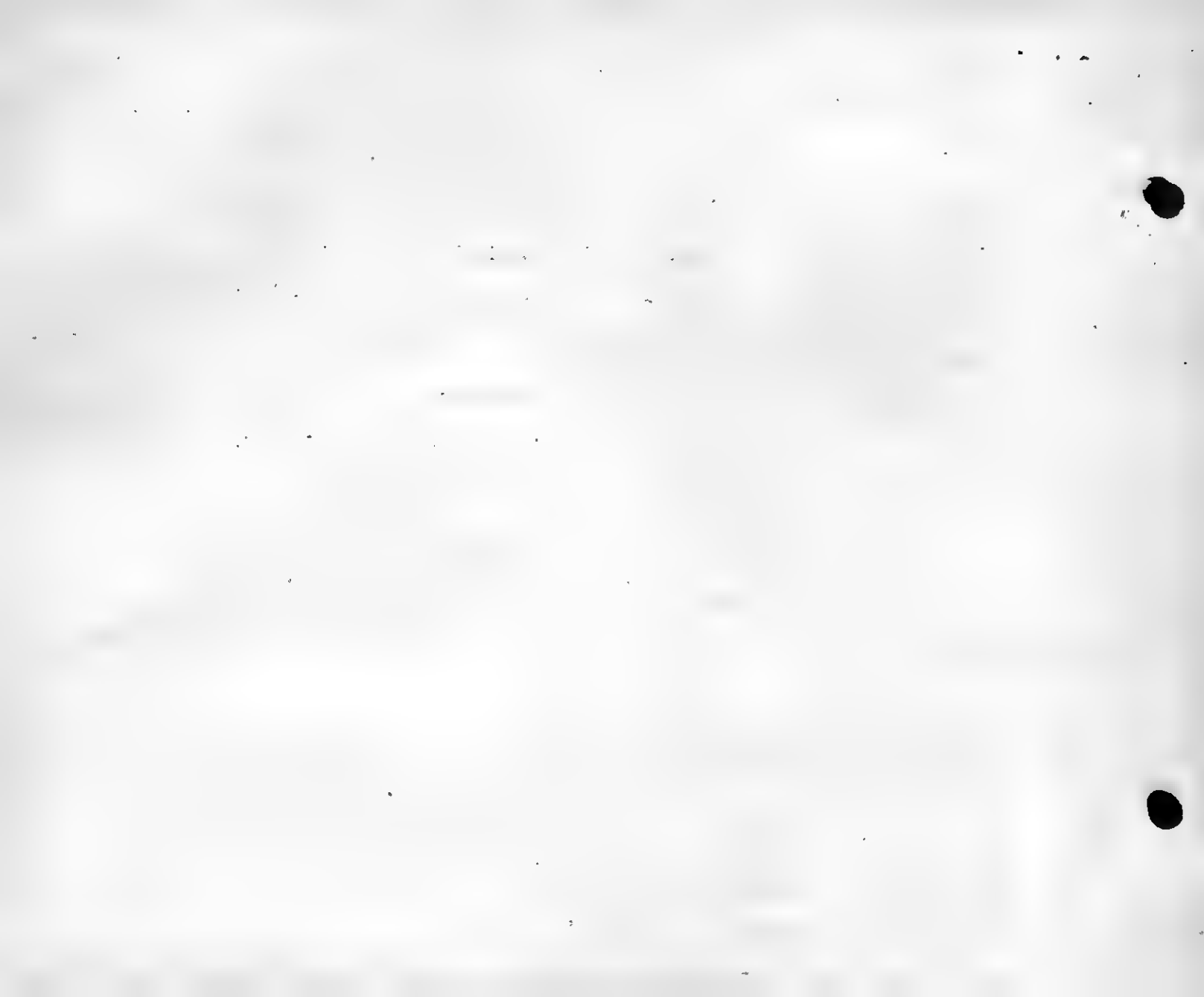
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11905

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

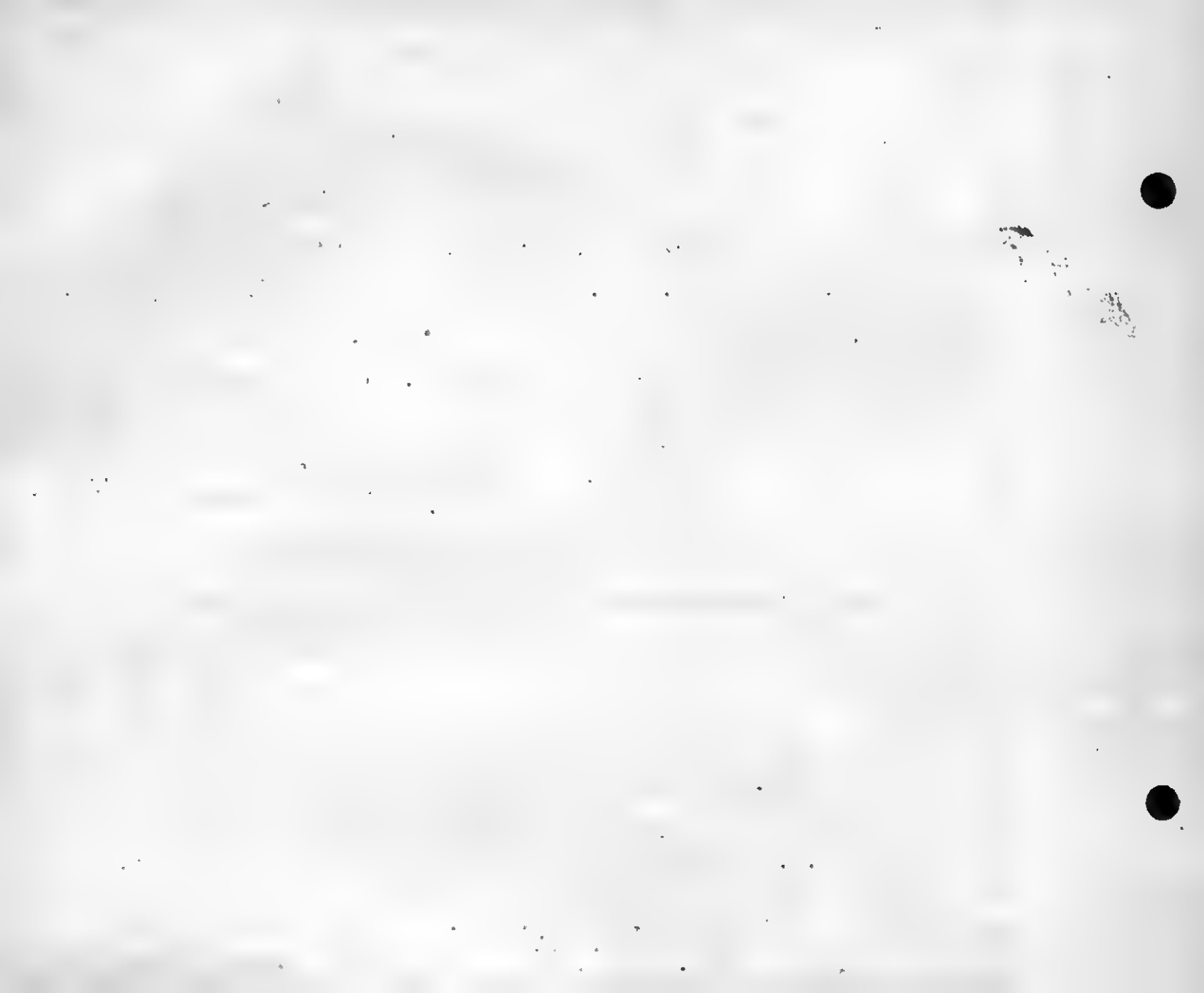
| | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|---|--|---|---|--|---|--|
| 1. DECEASED-NAME (Type or print) PAUL | | | First Middle Last M BROWNE | | | 2a. DATE OF DEATH Month August Day 27 Year 1968 | | | 2b. HOUR 650AM | | | | |
| 3 SEX male | | 4. RACE caucasian | | 5. DATE OF BIRTH January 31, 1902 | | | 6 AGE (In years lost birthday) 66 YRS | | | IF UNDER 24 HRS MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) Washington DC | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9 COUNTY OF DEATH Prince Georges | | | Md. | | | |
| 10 CITY OR TOWN OF DEATH Riverdale | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Pr Geo | | | 13c. CITY OR TOWN Mt. Rainier | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 3303 Bunker Hill | |
| 14. FATHER'S NAME First Middle Last Benjamin F Browne | | | 15. MOTHER'S MAIDEN NAME First Middle Last Laura E Shriver | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown unknown | | | 16b. SOCIAL SECURITY NO. 578 09 0058 | | | 17. INFORMANT Address hospital | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 4370 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) FRACTURED RIBS & CHEST INJURY | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 24 AUG, 1968 , to 27 AUG, 1968 , that (I) (we) lost saw the deceased alive on 25 AUG 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. DR. KENOE NOTIF-2 | | | | | | | | | | | | | |
| 22b. SIGNATURE C. J. HODMAN | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 27 AUG 68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) C. J. HODMAN | | | 22e. ADDRESS RIVERDALE MD | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) 1 | | | 23b. DATE Aug. 27-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State) 27 AUG 1968, Prince Georges, Md. | | | | |
| 24. FUNERAL DIRECTOR James Bros | | | ADDRESS 2161-3000 N. Ave | | | 25a. REC'D BY REGISTRAR AUG 29 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|--|--|---|-----------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| Julia Johanna Bruner | | | | | | Aug. Month 3 Day 68 Year | | 5:30 a.m. | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | |
| Female | | white | | 1 May 1881 | | 87 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Iowa | | USA | | | | Prince George's Md | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Bowie | | | 12609 Cherrywood Lane | | | housewife | | Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md | | | Pr. Geo. | | Bowie | | | | 12609 Cherrywood Lane | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Henry Waterstradt | | | Mary Schult | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> | | | -- | | Marian J. Bruner-daughter | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ch. Lymphocytic Leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>17 yrs</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>October, 19 65</u> , to <u>3 Aug.</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>15 July</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>R.B. Sasscer</u> | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED <u>8-3-68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) R.B. Sasscer | | | | 22e. ADDRESS Upper Marlboro, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Removal | | 8-7-68 | | Cedar Mem. Cem. | | Cedar Rapids, Iowa | | | | |
| 24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002 | | | | 25a. REC'D BY REGISTRAR DATE AUG 7 1968 | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11907

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11915

CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME (Type or print) First Middle Last CURTIS LEON BYRD | | | 2a. DATE OF DEATH Month Day Year AUG 27 1968 | | | 2b. HOUR 1:36 M | |
| 3. SEX MALE | | 4. RACE NEGRO | | 5. DATE OF BIRTH 9 Mar 27 | | 6. AGE (In years last birthday) 41 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Miss. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md. | |
| 10. CITY OR TOWN OF DEATH Andrews AFB | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAFHosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) U.S. Army | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Army | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Miss. | | 13b. COUNTY Purvis | | 13c. CITY OR TOWN Purvis | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER Rt 2 Box 190 | | 14. FATHER'S NAME First Middle Last EDDIE L. BYRD | | 15. MOTHER'S MAIDEN NAME First Middle Last BERTHA CLARA CARTER | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) Yes | | 16b. SOCIAL SECURITY NO. 1951-1968 428263544 | | 17. INFORMANT Address Bertha(w) same as item #13 | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory failure c Cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Pneumonia secondary to pseudomonas DUE TO, OR AS A CONSEQUENCE OF (c) pseudomallei APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 1 month | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 493 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 17 Aug , 19 68 , to 27 Aug , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 27 Aug , 19 68 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Arnold L. Klipstein | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 27 Aug 68 | |
| 22d. PHYSICIAN'S NAME (Type) ARNOLD L KLIPSTEIN CAPT USAF MC | | | | 22e. ADDRESS MALCOLM GROW USAFH ANDREWS AFB MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 9-3-68 | | 23c. NAME OF CEMETERY OR CREMATORY Community Cemetery | | 23d. LOCATION (City or Town) (County) (State) Purvis Miss | |
| 24. FUNERAL DIRECTOR W. W. Chambers Co. | | ADDRESS 1400 Chapin St | | 25a. REC'D BY REGISTRAR SEP 3 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

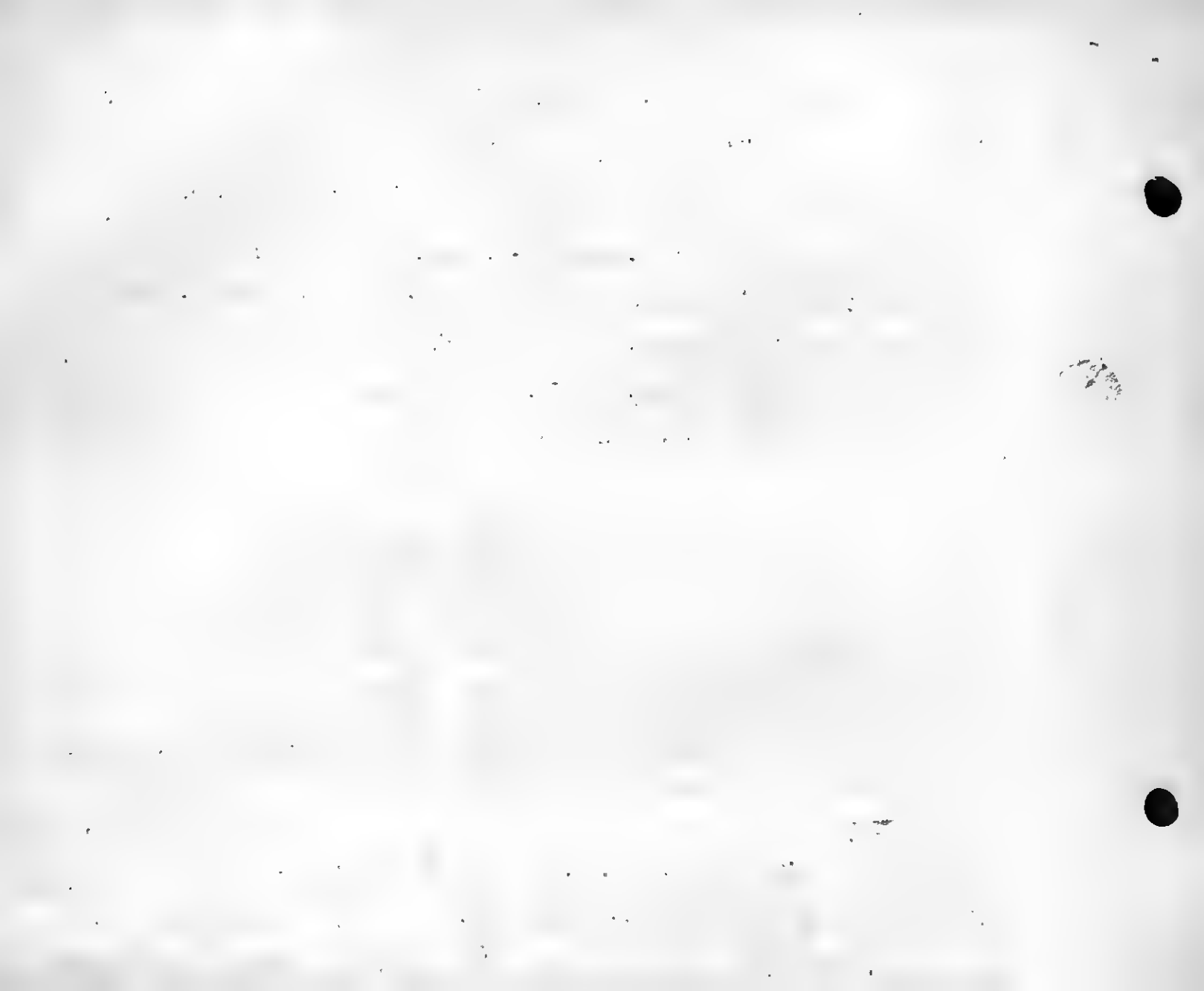
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED-NAME (Type or print) First Middle Last George J. Calavetinos | | | 2a. DATE OF DEATH August 3, 1968 | | 2b. HOUR 5:55AM |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH 8/8/01 | | 6. AGE (In years birthday) YRS. 66 | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) GREECE | 7b. CITIZEN OF WHAT COUNTRY? GREECE | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md. | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PRODUCE CLERK | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | 13b. COUNTY Prince George's | 13c. CITY OR TOWN Riverdale | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 4913 Riverdale Road |
| 14. FATHER'S NAME First Middle Last JAMES CALAUETINOS | | | 15. MOTHER'S MAIDEN NAME First Middle Last PORTA CHARAKAS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na. or unknown) (If yes give war or dates of service) NO | | 16b. SOCIAL SECURITY NO. 579076235 | | 17. INFORMANT Address Samus #13 FRANCES M. CALAUETINOS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Extensive cerebral infarct 43-1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 32X | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (X) (this hospital) attended the deceased from 6/28, 1968, to August 3, 1968, that (X) (we) last saw the deceased alive on August 3, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the cause stated above, (X) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Iradj Sadheghian M.D. | | | | 22c. DATE SIGNED August 5, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Iradj Sadheghian, M. D. | | | | 22e. ADDRESS Prince George's General Hospital, Cheverly, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 8-6-1968 | | 23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN | |
| 23d. LOCATION (City or Town) (County) (State) BALMAR MANOR, MD | | 23e. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD | | 23f. ADDRESS RIVERDALE, MD | |
| 24. FUNERAL DIRECTOR W.W. CHAMBERS CO. RIVERDALE, MD | | 25a. REC'D BY REGISTRAR DATE AUG 8 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Yunge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 6 Film G404 3-7-78 | | | | | | | | | | | | | | |
|--|--|---------|--|------------------|--|--|---------------------------------|----------------------|--|--|----------------------------|--|--|--|
| 11909 | | 11917 | | | | | | CERTIFICATE OF DEATH | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 20. DATE OF DEATH | | | 25. HOUR | | | | | |
| James L. Carrico | | | | | | Month Day Year 8 25 1968 | | | 7-15 P.M. | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | | |
| male | | white | | 5-29-83 | | | 85 1/2 YRS. | | | | | | | |
| 70. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | | |
| Virginia | | | U.S. | | | | | | Prince George | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Hyattsville | | | Hyattsville Nursing Home | | | Farmer | | | | | | | | |
| 130. USUAL RES. DENCE (Where deceased lived; if institution, Res. dence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIM. Y? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | | |
| Washington | | | | | | | | | | | | 1018 upshur St. N.E. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | | |
| Wm. Christopher Carrico | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | | | | |
| | | | 216-16-4146A | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> | | | | | | | | | | | | 2-3 yrs | | |
| 41-1 | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | year | | |
| (b) <u>atherosclerosis</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 420 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>year</u> , 19 <u>62</u> , to <u>Aug 25</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>Aug 25</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | | |
| E. L. M. - 1 | | | | | | | | | 8/25/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | 8/29/68 | | | Cedar Hill | | | Suitland Md | | | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Lee Funeral Home | | | 300 4th St. N.E. Wash. D.C. | | | DATE AUG 29 1968 | | | James Judge | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11970

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21818

| | | | | | | | | | | | |
|---|--------|-----------------------------|---|---|-----------------------------------|---|---|---|----------------------------------|--|------------|
| 1 DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year | | | 2b HOUR | | |
| George Fletcher Clayton | | | | | | 8-1-68 | | | 193:46amM | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years lost birthday) | 7 UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c DATE PRONOUNCED DEAD Month Day Year | | | 2d HOUR |
| Male | White | 9-14-1942 | 25 YRS | | | | | 8 1 68 | | | 194:10am M |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| D.C. | | U S A | | | | Prince George's Md | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Riverdale | | | Leland Memorial Hospital | | | Mail Carrier | | | U S Govt | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission only, STATE) | | | 13b COUNTY | | 13c CITY OR TOWN | | 13a INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | | |
| Maryland | | | Prince George's | | Laurel | | YES | | 312 Thomas Dr., Apt. 3 | | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | | |
| George F. Clayton | | | Dorothy P. O'Dae | | | | | | | | |
| 16a WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | 17 INFORMANT | | | ADDRESS | | | |
| None | | | 217422456 | | Sharon Clayton (Wife) | | | Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>Trauma - auto accident.</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF _____ | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 7224 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, if applicable) | | | | | |
| CAUSE OF DEATH | | | 3:45am 8-1- 1968 | | | Driver of car which went out of control and over turned. | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | | 21f LOCATION Street or R.F.D. No. | | | City or Town County State | | |
| | | | Rt. 198, Laurel, Prince George County, Md. | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | 22b DATE SIGNED | | | | | |
| John Kehoe | | | John Kehoe MD Riverdale, Md. | | | 8-1-68 | | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 8/3/1968 | | Ft. Lincoln Cemetery | | Colmar Manor, Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Nalley's Funeral Home Mt. Rainier, Md. | | | | | | DATE AUG 5 1968 | | J Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11911

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11919

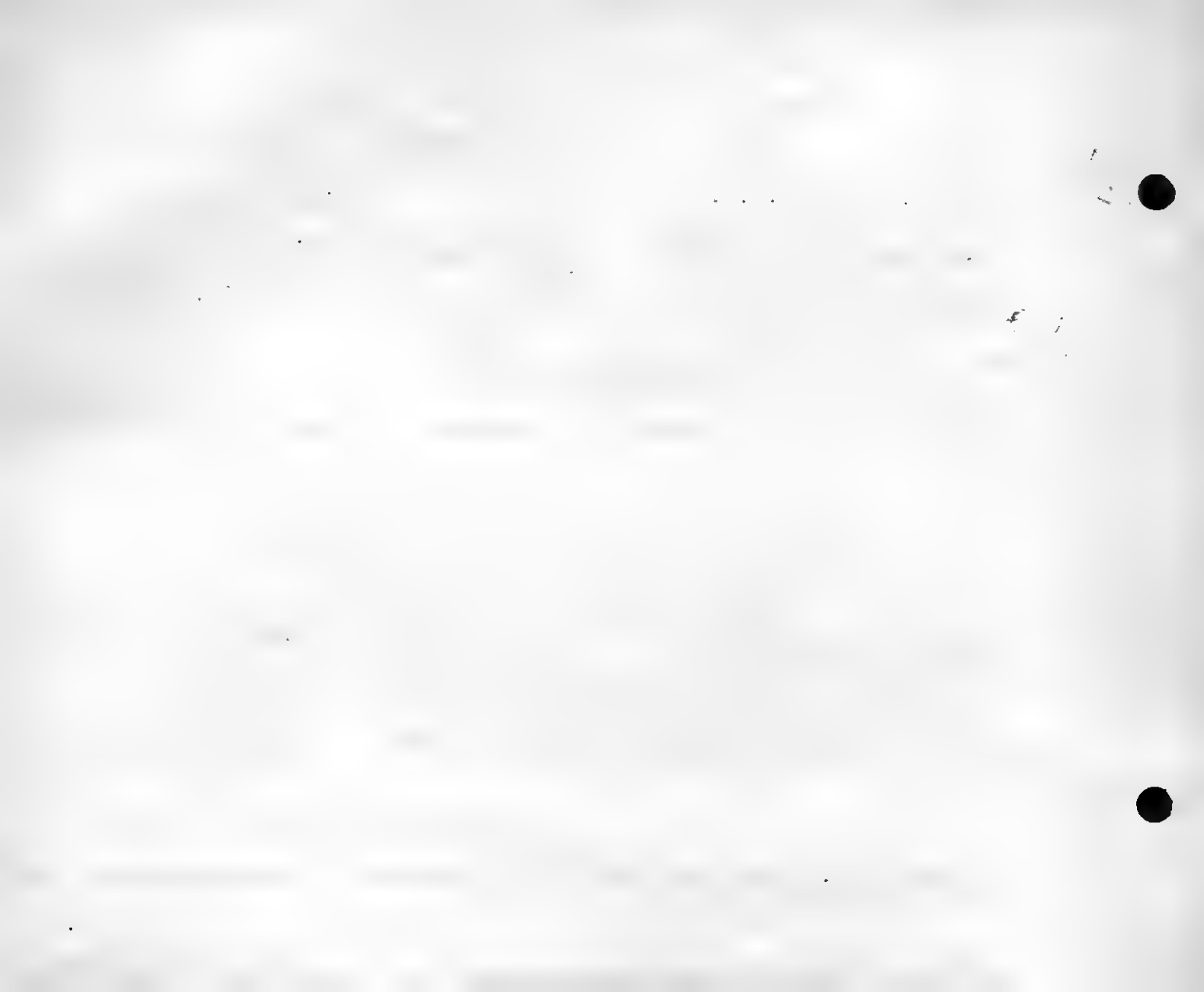
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|---|--|--|
| 1. DECEASED-NAME (Type or print) Sadie First M Middle Conwitz Last | | | 2a. DATE OF DEATH Month 8 Day 30 Year 68 | | | 2b. HOUR 6A M | | | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH 2-14-84 | | 6. AGE (In years last birthday) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) Ny | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Pr. George Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fine View Gardens | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House Wife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | | 13b. COUNTY Pr. George | | | 13c. CITY OR TOWN Clinton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 8338 Woodyard Rd. | |
| 14. FATHER'S NAME First Louis Middle Mock Last | | | 15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Md. | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | | 16b. SOCIAL SECURITY NO Unknown | | | 17. INFORMANT Shirley E. Smith, 8338 Woodyard Rd, Clinton, Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Circulatory Collapse 4129 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cardiovascular Arteriosclerosis (c) Cerebral Arteriosclerosis | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4129 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-22-1967 , to 8-30-1968 , that (I) (we) last saw the deceased alive on 8-30-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE Rever R. L. Lippert | | | | | | 22c. DATE SIGNED 8-30-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT Buried | | | 23b. DATE 9-3-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Clinton, Maryland | | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. SE, Suitland, Maryland | | | | | | 25a. REC'D BY REGISTRAR SEP 6 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|---|--|--|--|---|-----------------------|---|---|--|---|--|----------------------------------|---------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First MILDRED | | Middle W | | Last COPLAN | | 2a. DATE OF DEATH Month 28 Day 1968 ar | | | 2b. HOUR 6:25 M |
| 3. SEX FEMALE | | 4. RACE CAUC | | 5. DATE OF BIRTH 16 Sep 1920 | | | 6. AGE (In years at birthday) 47 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH Andrews AFB | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland | | | 13b. CITY OR TOWN Silver Springs | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER Apt 815 1131 Univ. Blvd West | | | | |
| 14. FATHER'S NAME First SAM | | | Middle WEISS | | Last XXXXXX | | 15. MOTHER'S MAIDEN NAME First XXXXXX | | Middle XXXXXX | | Last XXXXXX | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 204-07-2811 | | | 17. INFORMANT Sister Address | | | | | | |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic carcinoma of breast | | | | | | | | | | | | |
| 174x DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | | |
| 18 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 23 May 68 to 28 Aug 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 28 Aug 1968 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (do) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE William E. Palma | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 28 Aug 68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) WILLIAM E. PALMA, MAJ USAF MC | | | | | | 22e. ADDRESS MALCOLM GROW USAFH ANDREWS AFB MD | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden | | | 23d. LOCATION (City or town) (County) (State) Falls Church, Va. | | | | | |
| 24. FUNERAL DIRECTOR BERNARD DANZANSKY & SONS WASH, D.C. | | | | | | ADDRESS 3501 14th St. N.W. | | 25. RECEIVED BY REGISTRAR SEP 3 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

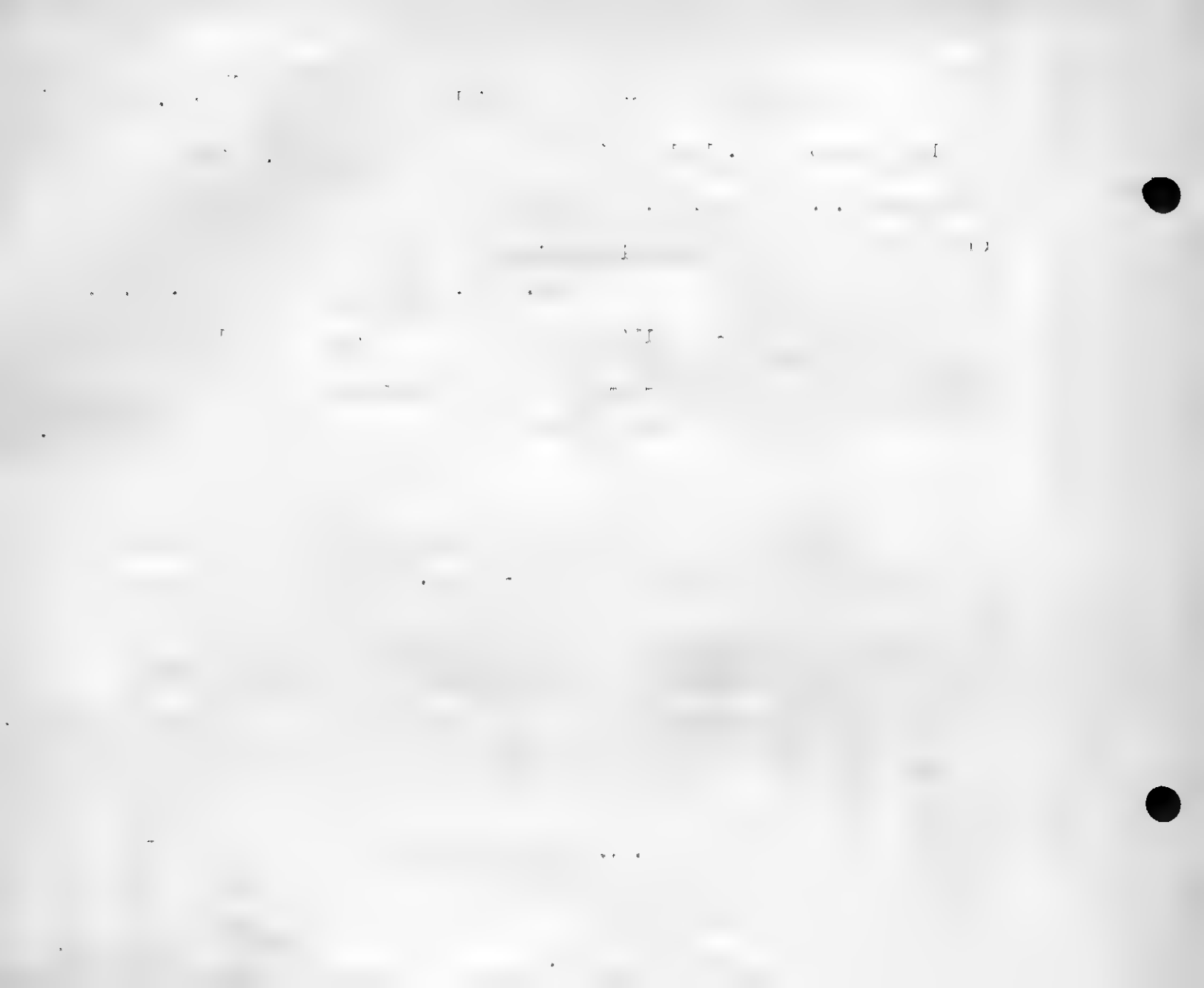


FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

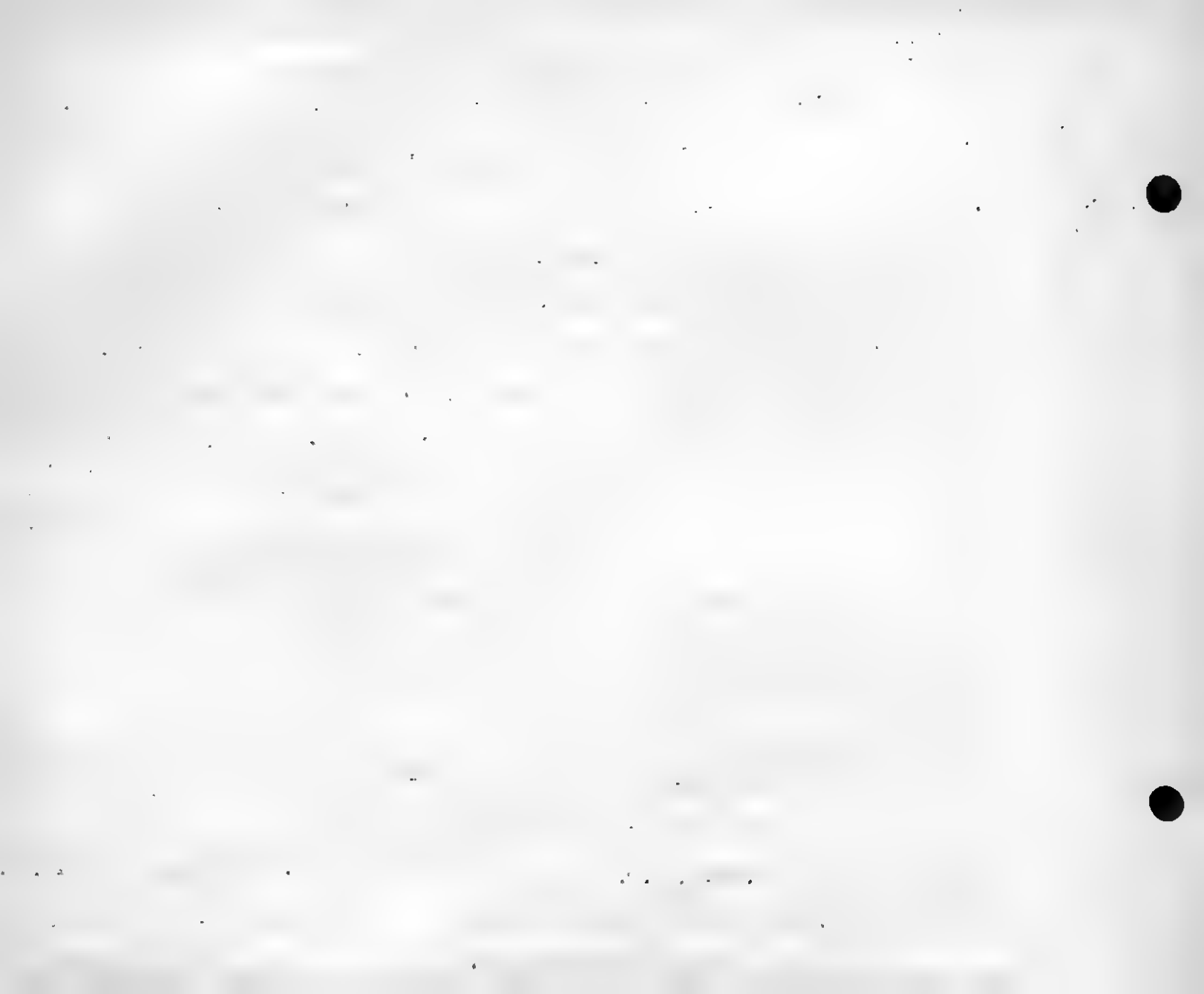
| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11/14/68kk11913 | | | | | | | | | | | | 11921 | |
|---|--|------------------------|--|---|--|--|------------------------|--|--|---|--|----------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First William | | Middle -- | | Last Daniels | | 2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI DEATH MATED <input type="checkbox"/> Month Day Year Aug. 26 1968 | | 2b. HOUR 7:35 AM | | |
| 3 SEX Male | | 4 RACE Negro | | 5 DATE OF BIRTH Apr. 16, 1930 | | 6 AGE (In years last birthday) 38 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Month Day Year Aug. 26 1968 | | 2d. HOUR 7:35 AM | |
| 7a. BIRTHPLACE (State or foreign country) Washington, D.C. | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Prince Georges | | | | |
| 10. CITY OR TOWN OF DEATH Glenn Dale | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Porter | | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE Wash., D.C. | | | 13b. COUNTY Wash., D.C. | | | 13c. CITY OR TOWN Wash., D.C. | | 13d. INSIDE CITY L.M. 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 300 50th St., N. E. | | | |
| 14. FATHER'S NAME First Middle Last Otis -- Williams | | | 15. MOTHER'S MAIDEN NAME First Middle Last Rosa Belle Ready | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown | | | 16b. SOCIAL SECURITY NO. 578-36-5589 | | | 17. INFORMANT Decedent | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 9800 DUE TO, OR AS A CONSEQUENCE OF Intoxication Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 421.7 (b) Barbiturates DUE TO, OR AS A CONSEQUENCE OF (c) Barbiturates | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hrs. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Paraplegia from tuberculoma of spine- 4 yrs. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year unknown 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Ingested overdose of barbiturates | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) Glendale Hosp | | | 21f. LOCATION Street or RFD No City or Town County State Glendale Prince George Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | | EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) | | | 22b. DATE SIGNED 8/14-27-68 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 8/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Cemtery | | | 23d. LOCATION (City or Town) (County) (State) Maryland | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS John T. Stewart 4001 Benning Rd. N.E. | | | | | | 25a. REC'D BY REGISTRAR DATE NOV 14 1968 | | 25b. REGISTRAR'S SIGNATURE Charles J. J... | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Irene | | Middle C. | | Last Davis | | 2a. DATE OF DEATH Month Aug. Day 31 Year 1968 | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Sept. 16, 1902 | | | 6. AGE (In years last birthday) 65 YRS. | | 7b. HOUR 3:00A M | |
| 7a. BIRTHPLACE (State or foreign country) West Virginia | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md | | | | |
| 10. CITY OR TOWN OF DEATH Riverdale | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospt | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | 13b. COUNTY P. G. | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 5312 43rd Avenue | | |
| 14. FATHER'S NAME First Michael Middle P. Last Maloney | | | 15. MOTHER'S MAIDEN NAME First Annie Middle Plummer Last Plummer | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) <input type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. no | | 17. INFORMANT Address Annie C. Whitfield Same as #13 | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acc & coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic hypertension DUE TO, OR AS A CONSEQUENCE OF (c) heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7c | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7c | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 21, 1962 , to Aug 31, 1968 , that (I) (we) last saw the deceased alive on May 16, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Till Bergemann | | | | DEGREE Professional Bldg., Centerway, Greenbelt, Md. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 8-31-68 | | |
| 22d. PHYSICIAN'S NAME (Type) Till Bergemann, M.D. | | | | 22e. ADDRESS Professional Bldg., Centerway, Greenbelt, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Sept 3, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Marydale Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR SEP 4 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |

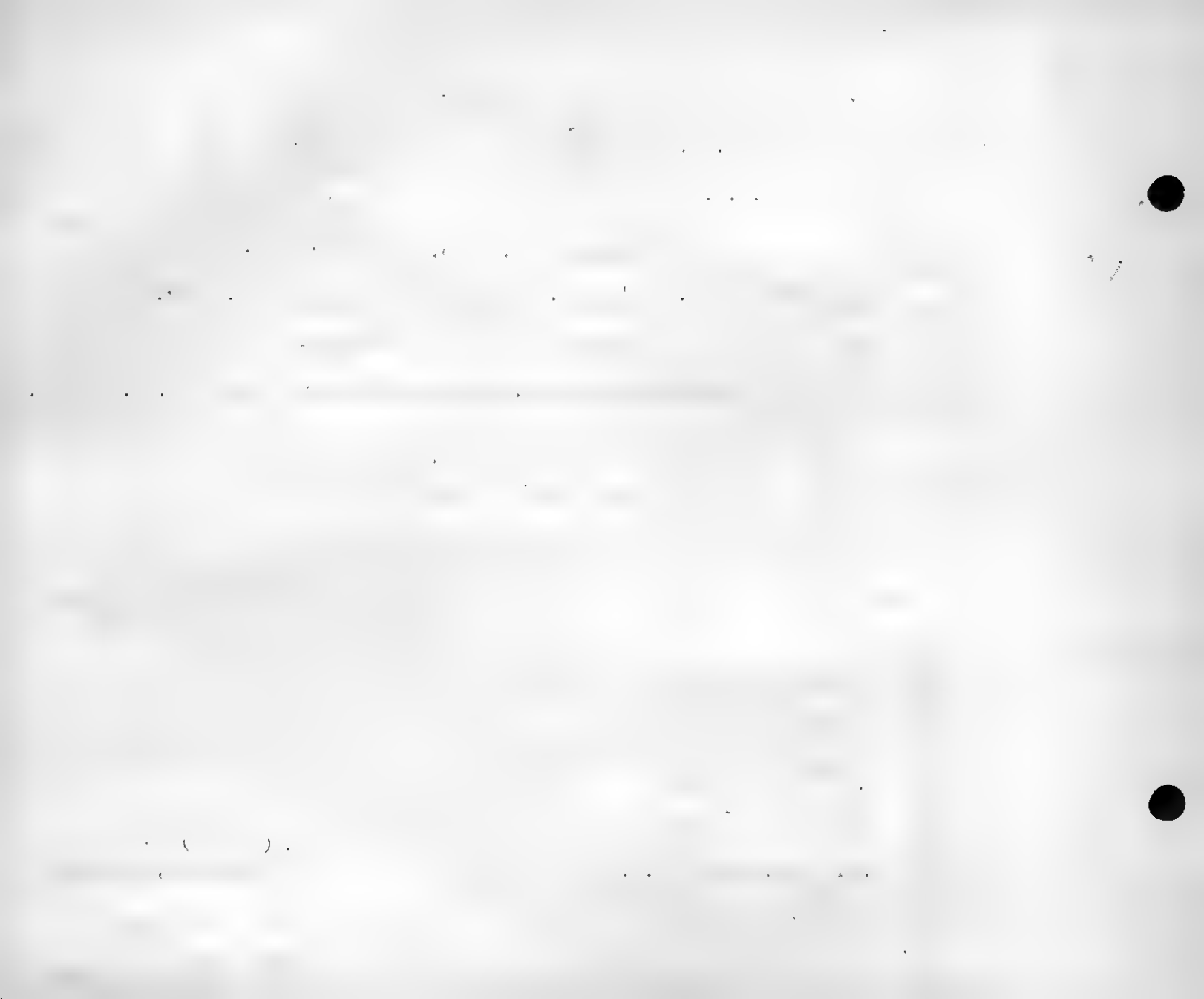


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 15 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | | | | |
|---|--|------------------------|--|---|--|--|--|---|---|---|--|--|----|--|-------------------|--|--------------------|--|------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) | | | First Harry | | | Middle Stoffer | | | Last Dawson | | | 2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8 23 19 68 | | 2b HOUR M | | | | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH Sept. 8, 1908 | | 6 AGE (In years) last 59 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c DATE PRONOUNCED DEAD Aug 24 68 19 | | 2d HOUR 2:20 PM | | | | | | |
| 7a BIRTHPLACE (State or foreign country) Virginia | | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Prince George's, | | | | Md | | | | | | | |
| 10 CITY OR TOWN OF DEATH Cheverly | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Georges Gen. Hosp. | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Upholsterer-retired | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | | 13b COUNTY Prince George's | | | | 13c CITY OR TOWN Mt. Rainier | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13b STREET AND NUMBER 3258 Queenstown Drive | | | | | | | | |
| 14 FATHER'S NAME John | | | First - | | | Middle - | | | Last Dawson | | | 15 MOTHER'S MAIDEN NAME Harriet Young Dawson | | | First - | | Middle - | | Last - | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | | (If yes give war or dates of service) World War II | | | | 16b SOCIAL SECURITY NO 578-09-4615 | | 17. INFORMANT Mrs. Geraldine Todd | | | | ADDRESS 5905 34th Ave. W. Hyatts. | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinomatosis 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Adenocarcinoma of the colon DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | |
| 22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Cornelius J. Burns, M.D. | | | | EXAMINER'S NAME (Type) Cornelius J. Burns, M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (Acting) 8-24-68 ADDRESS (Street, city, town, or county) Cheverly, Maryland | | | | 22b DATE SIGNED | | | | | | | | |
| 23a BURIAL CREMATION REMOVAL (Specify) burial | | | | 23b DATE 8/27/1968 | | | | 23c NAME OF CEMETERY OR CREMATORY Baltimore National | | | | 23d LOCATION (City or Town) (County) (State) Baltimore, Maryland | | | | | | | | |
| 24 FUNERAL DIRECTOR Valley's Funeral Home | | | | ADDRESS Mt. Rainier, Md. | | | | 25a REC'D BY REGISTRAR DATE AUG 27 1968 | | | | 25b REGISTRAR'S SIGNATURE J. Charles J... | | | | | | | | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11918

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1024

| | | | | | | | | | |
|--|--------|--|---|--|------|---|--|--|--|
| 1 DECEASED-NAME (Type or Print) | | | First | Middle | Last | 2a DATE KNOWN OF TEST <input type="checkbox"/> Month Day Year | | | 2b HOUR |
| Jackson Andrew Drew JR. | | | | | | 2c DATE OF DEATH MATED <input checked="" type="checkbox"/> 8-7-68 1910:20pm | | | 2d HOUR |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | 2e DATE PRONOUNCED DEAD Month Day Year | 2d HOUR |
| Male | White | 9-12-1927 | 40 YRS | | | | | 8 8 68 12:52am | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | Md. | |
| North Carolina | | U. S. A. | | | | Prince George's | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY |
| Cheverly | | | Prince George Hospital | | | Mechanic | | | Self-Employed Auto |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | Prince George's | | | Oxon Hill | | 6510 Livingston Road | |
| 14 FATHER'S NAME | | | First | Middle | Last | 15 MOTHER'S M A DEN NAME | | | First Middle Last |
| Andrew J. | | | | | Drew | Hattie | | | Allen |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | | ADDRESS |
| Yes | | | 8-20-44 12-22-47 | | | Louise Drew | | | 6510-Livingston Rd. N.E. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gun shot wound of head, | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 2D AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| | | | | 10:20pm 8-7- 1968 | | Shot self in head with .38 cal. revolver | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County | State |
| | | 7901 Old Branch Avenue | | Prince George County | | Maryland | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MED CAL EXAMINER <input type="checkbox"/> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b DATE SIGNED |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | 8-8-68 |
| John Kehoe MD | | | Riverdale, Md. | | | | | | |
| 23a BURIAL CREMATION REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | (State) |
| Burial | | 8-10-68 | | Washington National Cem | | Suitland | | Maryland | |
| 24 FUNERAL DIRECTOR | | | | 25a REC'D BY REG STRAR | | 25b REGISTAR'S SIGNATURE | | | |
| W.W. Chambers 517-11 th St. S.E. D.C. | | | | AUG 13 1968 | | Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MAYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|---|---|---|--|--|---|--|
| 11917 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED NAME (Type or print) Father Francis G. Driscoll | | | 2a DATE OF DEATH Month 8 Day 16 Year 68 | | | 2b. HOUR 12:45 PM | | | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH 3-20-1899 | | 6 AGE (In years last birthday) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md. | | | |
| 10. CITY OR TOWN OF DEATH Haghtsville | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Manor 4922 La Salle Rd | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clergy | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland COUNTY Prince George | | 13b. CITY OR TOWN Haghtsville | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER 4420 Belair Rd. | | | |
| 14 FATHER'S NAME First Frank Middle Driscoll Last Driscoll | | | 15. MOTHER'S MAIDEN NAME First Anastasia Middle Fogarty Last Fogarty | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown) No (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 217-44-2823A | | 17 INFORMANT Sister M. Dominis - 4922 La Salle Rd - Haghtsville Md. | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Hemorrhage | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f. LOCATION Street or RFD No | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/6/68 , 19 68 , to 8/16/68 , 19 68 , that (I) (we) last saw the deceased alive on 8/16/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour, and from the causes stated above, (I) (we) (did) (did not) view the body after death I did view body after death | | | | | | | | | |
| 22b. SIGNATURE John J. Sweeney MD DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | 22c. DATE SIGNED 8/16/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. H. W. Sweeney MD | | | | | 22e. ADDRESS 1905 Waterwood Place Silver Spring Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 8/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY New Cathedral | | 23d. LOCATION (City or Town) (County) (State) Baltimore Md | | | |
| 24. FUNERAL DIRECTOR W. W. Waller 3603 15th St NW | | | | | 25a. REC'D BY REGISTRAR AUG 20 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11918

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11926

CERTIFICATE OF DEATH

| | | | | |
|--|---|---|---|--|
| 1. DECEASED NAME (Type or print) First Middle Last John D. Driscoll | | 2a. DATE OF DEATH Month Day Year Aug. 27 1968 | | 2b. HOUR 11 PM |
| 3 SEX Male | 4 RACE White | 5. DATE OF BIRTH Dec. 21 1927 | 6. AGE (In years last birthday) 40 YRS. | 7. UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign country) Conn. Vt. | | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Chesley | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. George's Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None | 12b. KIND OF BUSINESS OR INDUSTRY None |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Vt. | | 13b. COUNTY Franklin | 13c. CITY OR TOWN Chesley | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME First Middle Last John Driscoll | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary J. Kelly | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | 17. INFORMANT John J. Driscoll - Same as # 12 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension, Atherosclerosis</u> | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE <u>T.F. O'Donovan</u> | | 22c. DATE SIGNED Aug. 27, 1968 | | 22d. PHYSICIAN'S NAME (Type) T.F. O'Donovan |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE Aug. 20-68 | 23c. NAME OF CEMETERY OR CREMATORY Catholic Hill Cemetery | 23d. LOCATION (City or Town) (County) (State) Chesley, Vt. |
| 24. FUNERAL DIRECTOR Simmons Bros. 1661-Gd. | | 25a. REC'D BY REGISTRAR DATE AUG 30 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11919

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--------------|--|--|---|--|--|--|--|--|---|--|
| 1. DECEASED-NAME (Type or Print) | | First Olga | | Middle | | Last Dugan (DZUGAN) | | 2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 8 8 68 | | 2b. HOUR 7:00 PM | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH 26 JUNE 1898 | | 6. AGE (In years last birthday) 70 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c. DATE PRONOUNCED DEAD Month 8 Day 8 Year 1968 | |
| 7a. BIRTHPLACE (State or foreign country) AUSTRIA | | 7b. CITIZEN OF WHAT COUNTRY? U. S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md | | | | | |
| 10. CITY OR TOWN OF DEATH Camp Springs | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Andrews AFB Hosp | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut an. Residence before admission) STATE Md. | | 13b. COUNTY Prince George | | 13c. CITY OR TOWN Camp Springs | | 3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 6210 Summer Hill Rd. | | | |
| 14. FATHER'S NAME First Middle Last HOMER | | 15. MOTHER'S MAIDEN NAME First Middle Last UNKNOWN | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16b. SOCIAL SECURITY NO (If yes give year or dates of service) 167-388301 | | 17. INFORMANT MRS JULIA RUSSELL | | ADDRESS SAME AS #13 | |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertensive vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH over 5 yrs. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | John Kehoe, M.D., Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8-9-68 | | ADDRESS (Street, city, town, or county) | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 8-12-1968 | | 23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEM | | 23d. LOCATION (City or Town) (County) (State) HANOVER TOWNSHIP PENNA. | | | | | |
| 24. FUNERAL DIRECTOR W.W. CHAMBERS CO RIVERDALE, MD | | | | 25a. RECD BY REGISTRAR DATE AUG 13 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

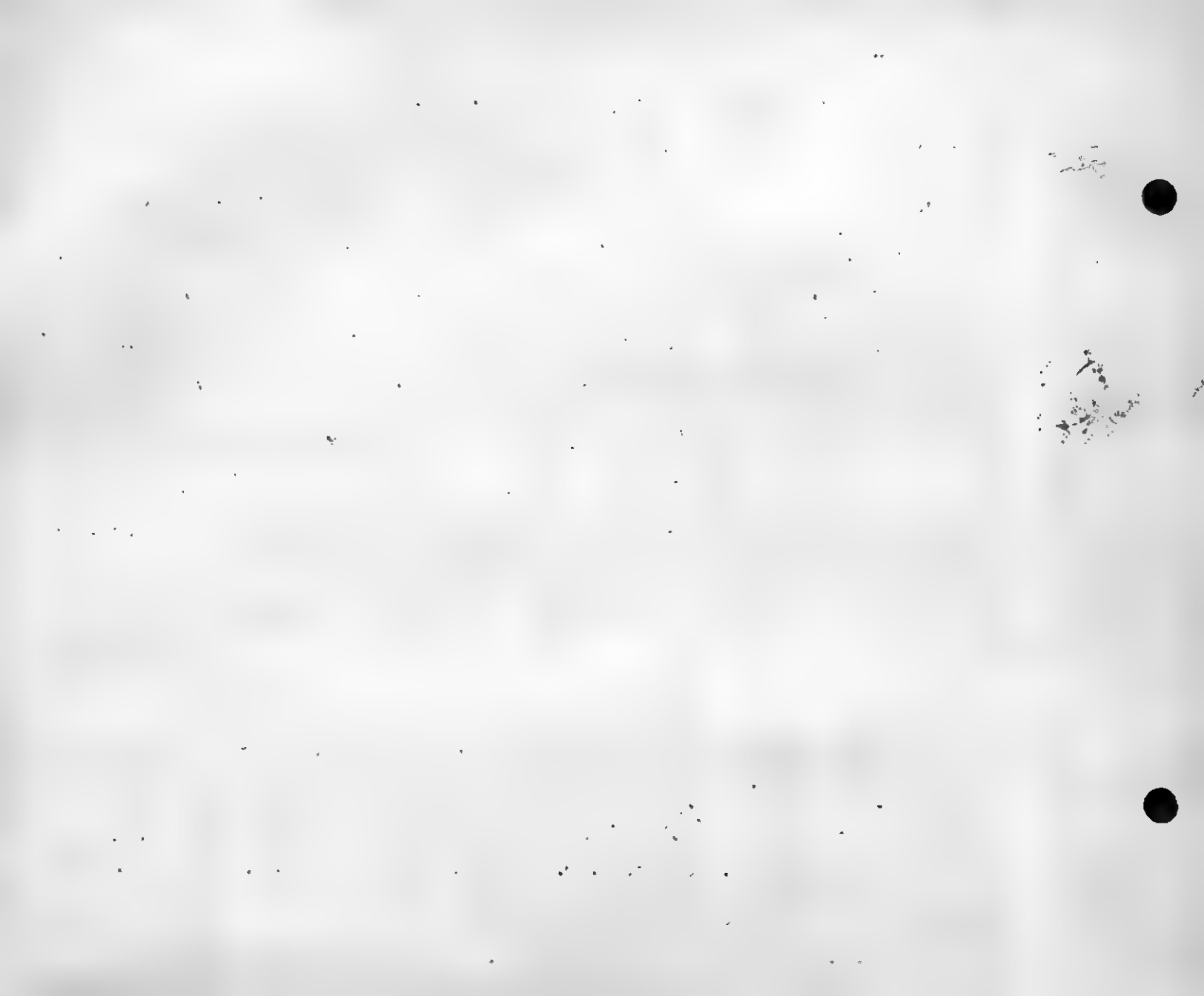
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11920

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

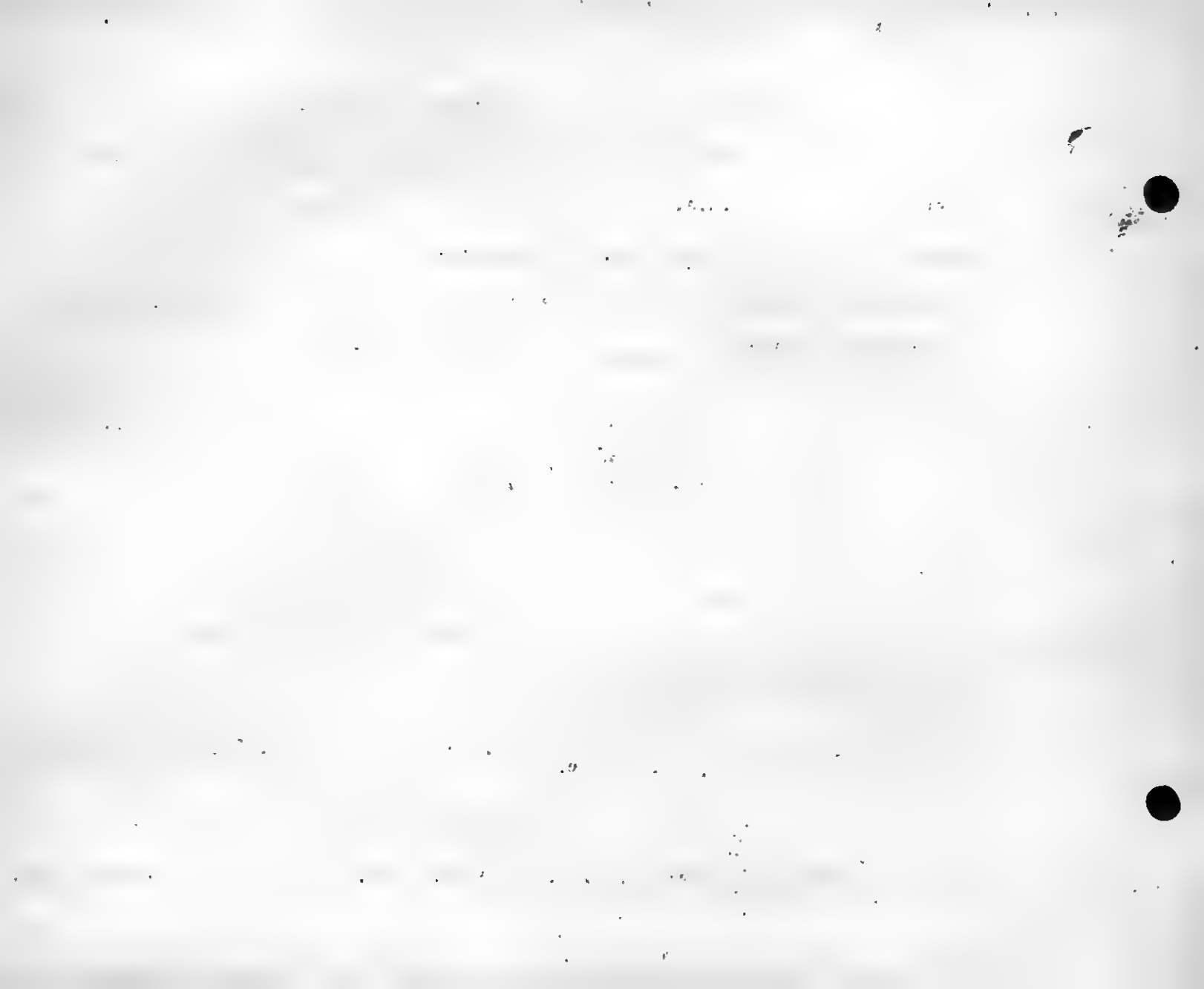
CERTIFICATE OF DEATH

| | | | | | | | | | | |
|--|--|---|--|--|--|---|---|---|--|--|
| 1. DECEASED-NAME (Type or print) <u>LEON ALICE</u> | | | 2a. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1968</u> | | | 2b. HOUR <u>3:44</u> M | | | | |
| 3 SEX <u>M</u> | | 4. RACE <u>WHITE</u> | | 5. DATE OF BIRTH <u>July 17 1912</u> | | 6 AGE (In years last birthday) <u>56</u> YRS. | | IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN | | |
| 7a. BIRTHPLACE (State or foreign country) <u>NEW YORK</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <u>PRINCE GEORGES</u> Md | | | | |
| 10. CITY OR TOWN OF DEATH <u>ANN ARBOR</u> | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>St. Joseph's</u> | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Teacher</u> | | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>MI</u> | | | 13b. COUNTY <u>Washtenaw</u> | | 13c. CITY OR TOWN <u>Ann Arbor</u> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER <u>1111 E. Washington</u> | |
| 14 FATHER'S NAME First <u>Paul</u> Middle <u>John</u> Last <u>Bohrer</u> | | | 15 MOTHER'S MAIDEN NAME First <u>Helen</u> Middle <u>Marie</u> Last <u>Bohrer</u> | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW2</u> | | | 16b SOCIAL SECURITY NO. <u>508 22 0392</u> | | 17 INFORMANT <u>Norman K. Bohrer</u> | | | Address <u>301 W. Preston St. Baltimore, Md.</u> | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>None</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) <u>(the husband)</u> attended the deceased from <u>July 17, 1912</u> to <u>July 15, 1968</u> , that (I) <u>did</u> saw the deceased alive on <u>July 15, 1968</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Norman K. Bohrer</u> | | | | DEGREE <u>MD</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED <u>Aug 15, 1968</u> | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Norman K. Bohrer, M. D.</u> | | | | 22e ADDRESS <u>3231 Superior Lane, Bowie, Md. 20715</u> | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE <u>Aug 15, 1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Tecumseh Cemetery</u> | | | 23d LOCATION (City or Town) (County) (State) <u>Tecumseh Johnson Nebraska</u> | | | |
| 24 FUNERAL DIRECTOR <u>F. Gasch's Sons</u> | | | | ADDRESS <u>Hyattsville, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>AUG 15 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u> | | |



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 11922 | | | | | | | | | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 11030 | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) First Middle Last Baby Boy Edwards | | | | | | | | | | 2a. DATE OF DEATH Month Day Year August 20, 1968 | | | | | | | | | | 2b. HOUR 4:45AM | | | | | | | | | |
| 3 SEX Male | | | | | 4. RACE Caucasian | | | | | 5. DATE OF BIRTH August 18, 1968 | | | | | 6 AGE (In years last birthday) YRS MONTHS DAYS 2+ | | | | | 7 UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9 COUNTY OF DEATH Prince George's Md | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo.Gen'l Hospital | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE Maryland | | | | | 13b COUNTY Prince George's | | | | | 13c CITY OR TOWN Cheverly | | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e STREET AND NUMBER 6420 Kilmer Street | | | | | | | | | |
| 14 FATHER'S NAME First Middle Last James Martin Edwards | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Brenda Jay Carrich | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Prematurity 116.1 DUE TO, OR AS A CONSEQUENCE OF (b) Atelectasis, bilateral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 116.2 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Aug. 18, 1968 , to Aug. 20, 1968 , that (X) (we) last saw the deceased alive on Aug. 20, 1968 , and that (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Bernardo Alvarado, M. D. | | | | | 22c. DATE SIGNED August 20, 1968 | | | | | 22d. ADDRESS Prince Geo.Gen'l Hospital, Cheverly, Md. | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D. | | | | | 22e. ADDRESS Prince Geo.Gen'l Hospital, Cheverly, Maryland | | | | | 22f. REC'D BY REGISTRAR SEP 5 1968 | | | | | | | | | | 22g. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE 8/31/68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Prince George's General | | | | | 23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR James W. Bennett, Jr. | | | | | ADMINISTRATOR James W. Bennett, Jr. | | | | | | | | | | | | | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in, and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

11821

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11829

| | | | | | | | |
|---|--|---|---|--|--|--|--|
| 1 DECEASED-NAME (Type or print) First Middle Last Alease B Elliott | | | 2a. DATE OF DEATH Month Day Year 8-16-1968 | | | 2b. HOUR 7:50 PM | |
| 3. SEX FEMALE | | 4 RACE NEGRO | | 5. DATE OF BIRTH 5-29-1900 | | 6. AGE (In years last birthday) 68 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) IND. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH PRINCE GEORGES Md. | |
| 10. CITY OR TOWN OF DEATH Forestville | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WASHINGTON DC | | 13b. COUNTY DC | | 13c. CITY OR TOWN WASHINGTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 444 Irving St. N.W. | | 14 FATHER'S NAME First Middle Last William - Bruce | | 15. MOTHER'S MAIDEN NAME First Middle Last Lucy Gee | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN | | 16b. SOCIAL SECURITY NO UNKNOWN | | 17 INFORMANT SON | | Address Edward Northampton - 444 Irving St. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive Pulmonary Hemorrhage 1621 DUE TO, OR AS A CONSEQUENCE OF (b) Bronchogenic Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Severed months | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1621 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 5, 1968 , to August 3, 1968 , that (I) (we) lost saw the deceased alive on August 3, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richard Ahlson, M.D. | | | | 22c. DATE SIGNED 8-10-1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS 1806 "D" St. N.E. Wash. DC | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 8/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Ceme. | | 23d. LOCATION (City or Town) (County) (State) Maryland | |
| 24. FUNERAL DIRECTOR John L. Stewart | | 24b. ADDRESS 2400 N.E. 1st St. - Funeral Home | | 25a. REC'D BY REGISTRAR DATE AUG 14 1968 | | 25b. REGISTRAR'S SIGNATURE James J. Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) ORA First EVANS Last | | | | | | 2a. DATE OF DEATH 8 Month 1 Day 68 Year | | 2b. HOUR 6A M | | | |
| 3 SEX F | | 4. RACE NEGRO | | 5. DATE OF BIRTH 3-10-81 | | 6. AGE (In years last birthday) 86 YRS. | | F. UNDER 1 YEAR MONTHS DAYS | | H. UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH PRINCE GEORGE Md. | | | | | |
| 10. CITY OR TOWN OF DEATH CLINTON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PINEVIEW GARDENS | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) None | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MD WASH. | | 13b. COUNTY D.C. | | 13c. CITY OR TOWN D.C. | | 13d. INSIDE CITY LIM TSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 5422 NASH ST 20027 | | | |
| 14. FATHER'S NAME First NED Middle Last JOHNSON | | | | 15. MOTHER'S MAIDEN NAME First CORA Middle Last P | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT CORA LEE HAGANS | | Address SAME | | | | | |
| 18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) AORTIC STENOSIS DUE TO, OR AS A CONSEQUENCE OF (c) RHEUMATIC HEART DISEASE | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN. + 20 YRS. + 30 YRS. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> None | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? None | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR COMBUTING CAUSE OF DEATH (If either, not by accident, state cause) None | | 21b. TIME OF INJURY HOUR A.M. Month Day Year None | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) None | | | | | | | |
| 21d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/> on way to or from work <input type="checkbox"/> None | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) None | | 21f. LOCATION Street or RFD No City or Town County State None | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 5/18/1967 , to present , that (we) last saw the deceased alive on 7/30/1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Arthur Shaver Jr. MD | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | 22c. DATE SIGNED 3/1/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. MD | | | | 22e. ADDRESS 8808 BRANCH AVE CLINTON | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE 8-3-68 | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) ROCKY MOUNT, N.C. | | | | | |
| 24. FUNERAL DIRECTOR Frazier F.H. | | | | ADDRESS 389 R.F. ave | | 25a. REC'D BY REGISTRAR AUG 6 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11922

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11932

| | | | | | | | | | | | |
|--|--|---|--|--|-----------|---|--|---|-----------------------------------|--|------|
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR | | |
| Baby Girl Fernandez | | | | | | Aug. 4, 1968 | | | 7:40PM | | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| Female | | Caucasian | | August 4, 1968 | | YRS. | | 1 | | 47 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| Maryland | | U.S.A. | | | | Prince George's | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince Geo.Gen'l Hospital | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Prince George's | | | Hyattsville | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 8124 14th Avenue | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Manuel | | | | | Fernandez | Rose M. Bonal | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity.</u> <u>1111X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1111X</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| 22a. I certify that (I) (who hospital) attended the deceased from <u>Aug. 4, 1968</u> , to <u>Aug. 4, 1968</u> , that (I) (xx) lost saw the deceased alive on <u>Aug. 4, 1968</u> , and that in (my) (xxx) opinion death occurred on the date and hour and from the causes stated above, (I) (xxx) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Francisco Venegas MD</u> | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>8-6-68</u> | |
| 22d. PHYSICIAN'S NAME (Type) <u>Francisco Venegas, M. D.</u> | | | | | | 22e. ADDRESS <u>3201 Sage Lane, Bowie, Md. 20715</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>8/17/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Prince Geo. General Hosp.</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>Cheverly, Maryland</u> | | | | |
| 24. FUNERAL DIRECTOR <u>HARRY W. PENN, JR. ADMINISTRATOR</u> | | | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 20 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be turned over to the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 11925 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Angela</i> | | | First Middle Last <i>Fitzgerald</i> | | | 2a. DATE OF DEATH 8 Month 12 Day 68 Year | | 2b. HOUR 11 P. M. | |
| 3 SEX <i>Female</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH <i>Sept. 12, 1900</i> | | 6. AGE (In years last birthday) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Prince Georges</i> Md. | | | |
| 10. CITY OR TOWN OF DEATH <i>Lanham</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Magnolia Gardens Nursing Home</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Manager</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Real Estate</i> | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Prince Georges</i> | | 13c. CITY OR TOWN <i>Hyattsville</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>5605 Monroe St.</i> | |
| 14. FATHER'S NAME First Middle Last <i>Richard A Fitzgerald</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary A Mc Dermott</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>577 07 6740A</i> | | 17. INFORMANT <i>Mary C. Taylor</i> | | Address <i>Landover Hills, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4200</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio-Sclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Nephritis</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDIT. ON FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Oct. 24, 1965</i> , to <i>Aug 12, 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug. 12, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Leon Levitsky</i> | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED <i>Aug 12, 1968</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Leon Levitsky</i> | | 22e. ADDRESS <i>3408 R I ave Mt Rainier, Md.</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>Aug 16, 1968</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt Olivet Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Washington D. C.</i> | | | |
| 24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i> | | ADDRESS <i>Hyattsville, Md.</i> | | 25a. REC'D BY REGISTRAR <i>Charles Judge</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |
| DATE <i>AUG 15 1968</i> | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

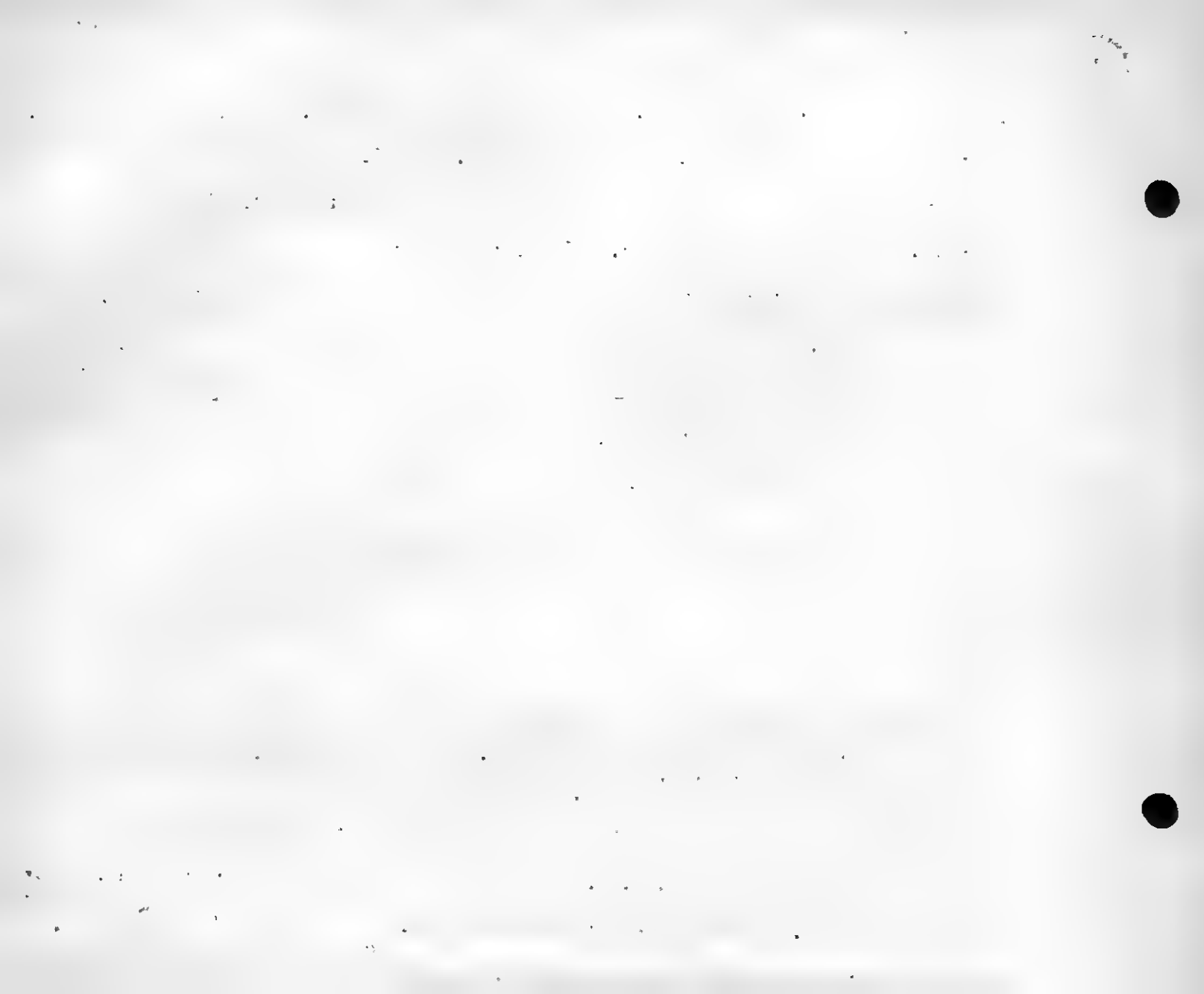
11926

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11934

| | | | | | | | | |
|--|--|--|---|---|--------------------------------------|---|----------|--|
| 1 DECEASED-NAME (Type or print) | | First | Middle | Lost | 2a DATE OF DEATH Month Day Year | | 2b. HOUR | |
| James M. Fowler | | | | | Aug. 4, 1968 | | 2 P. M. | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | F. UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN |
| Male | Caucasian | Jan. 17, 1891 | | | 77 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Maryland | USA | | | Prince George's Md | | | | |
| 10 CITY OR TOWN OF DEATH | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cheverly | Prince Geo. Gen'l Hospital | | FARMER | | U.S.A. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER | | | | |
| Maryland | Prince George's | Lanham | YES <input type="checkbox"/> NO <input type="checkbox"/> | 5004 West Lanham Drive | | | | |
| 14 FATHER'S NAME First Middle Lost | | 15. MOTHER'S MAIDEN NAME First Middle Lost | | | | | | |
| Sutton Fowler | | Virginia Better | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | | | |
| no | | 219-16-1735 | | 5004 West Lanham Drive James G. Fowler Hyattsville, Md. 20784 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>ATRIAL FIBRILATION</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>DEHYDRATION + ELECTROLYTES IMBALANCE</u> | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 4331 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | |
| | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from <u>Aug. 3, 1968</u> , to <u>Aug. 4, 1968</u> , that (X) (we) last saw the deceased alive on <u>Aug. 4, 1968</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE <u>Iradj Sadeghian</u> DEGREE | | | | ATTENDING <input type="checkbox"/> MED <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYS DIRECTOR PHYS | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Iradj Sadeghian, M. D.</u> | | | | 22e. ADDRESS <u>Prince George's General Hospital, Cheverly</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) | | |
| Burial | | Aug. 7, 1968 | | Mt. Harmony Chr. Cemetery Owings | | Calvert Md. | | |
| 24. FUNERAL DIRECTOR <u>State Union Funeral Home</u> | | | | ADDRESS <u>Owings, Md.</u> | | 25a. REC'D BY REGISTRAR DATE <u>AUG 9 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |



CERTIFICATE OF DEATH

11927

35

| | | | | | | | | | | | | | |
|---|--|-----------|--|--|---|---|--|--|--|---|--|-------------------------------------|--|
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR | | | | |
| Terrell | | | C | | Freemon | August 16, 1968 | | | 3:35A M | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS. HOURS MIN | | |
| Male | | Caucasian | | March 9, 1897 | | | 71 YRS. | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md | |
| Louisanna | | | U S A | | | | | | Prince George's | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | | | Prince Geo. Gen'l Hospital | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | | Prince George's | | | | Hyattsville | | | | 3903 Oglethorpe St. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last | | |
| Robert C | | | | | Freemon | Annie W | | | | | Terrell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | Address | |
| no | | | | 578 38 7229 | | | | Annie M Freemon | | | | Hyattsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | |
| 22a. I certify that (I) <u>physician</u> attended the deceased from <u>7/29</u> , 19 <u>61</u> , to <u>Aug. 16</u> , 19 <u>68</u> , that (I) <u>was</u> last saw the deceased alive on <u>Aug 15</u> , 19 <u>68</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert Deitz</u> | | | | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED August 16, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Robert Deitz, M. D | | | | | | 22e. ADDRESS Prince Geo. Plaza, Hyattsville, Md. 20783 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Aug 17, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | | | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville Md. | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE AUG 19 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11928

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|---|--|--|-------------------|---|--|--|-----------------------------------|--|------|
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR | | |
| Lois J. Frisco | | | | | | Aug. 18, 1968 | | | 6:20AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Female | | Caucasian | | July 15, 1940 | | 28 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Washington D C | | U S A | | | | Prince George's | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince Geo.Gen'l Hospital | | | none | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut on- Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Prince George's | | Bowie | | | | Box 150, Rt. 1, Bowie | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| George E Frisco | | | | | | Louise L Snesen | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| no | | | none | | | George E Frisco | | | Bowie, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute bacterial endocarditis.</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) XXXXXX attended the deceased from <u>Aug. 9, 1968</u> , to <u>Aug. 18, 1968</u> , that (I) XX saw the deceased alive on <u>Aug. 18, 1968</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Arthur Kaufman</u> | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED <u>19 Aug 68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Arthur Kaufman, M. D.</u> | | | | | | 22e. ADDRESS <u>Professional Bldg., Centerway, Greenbelt</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) | | 23e. REGISTRAR'S SIGNATURE | | | |
| Burial | | Aug 21, 1968 | | Ft Lincoln Cemetery | | Colmar Manor Maryland | | Md. | | | |
| 24. FUNERAL DIRECTOR | | F. Gasch's Sons | | Hyattsville, Md | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |
| | | | | | | AUG 22 1968 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 23a Film 610-110018-1A | | | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|-----------------------------------|--|
| 11023 | | | | | | 1968 | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| Ben Garner | | | | | | Aug. 18, 1968 | | | | 3:45 PM | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| Male | | Negro | | Mar 24-1890 | | 78 YRS. | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Md | | USA | | | | Prince George's Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | | | Prince Geo. Gen'l Hospital | | | | | | | | Dancing | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | | | Prince George's | | Lanham | | | | 9111 Crandall Rd. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| George | | | | Sarah | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | |
| Yes, no, or unknown | | | | | | Martha Garner - address above | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolism. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Right upper lobe pneumonia. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Bronchiectasis. | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21a. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from August 1, 1968, to August 18, 1968, that (X) (we) last saw the deceased alive on August 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) did (do not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Saul Rosen, M. D. | | | | | | | | | | 8-19-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | | | |
| Saul Rosen, M. D. | | | | | | Prince George's General Hospital, Cheverly, | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) | | 23e. REGISTRAR'S SIGNATURE | | | | | |
| Burial | | 8-23-68 | | Harmony Memorial | | Highland Park, Md | | Charles Jones | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| H.S. Washington & Son | | | | | | 4925 Deane Ave NE | | DATE AUG 22, 1968 | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

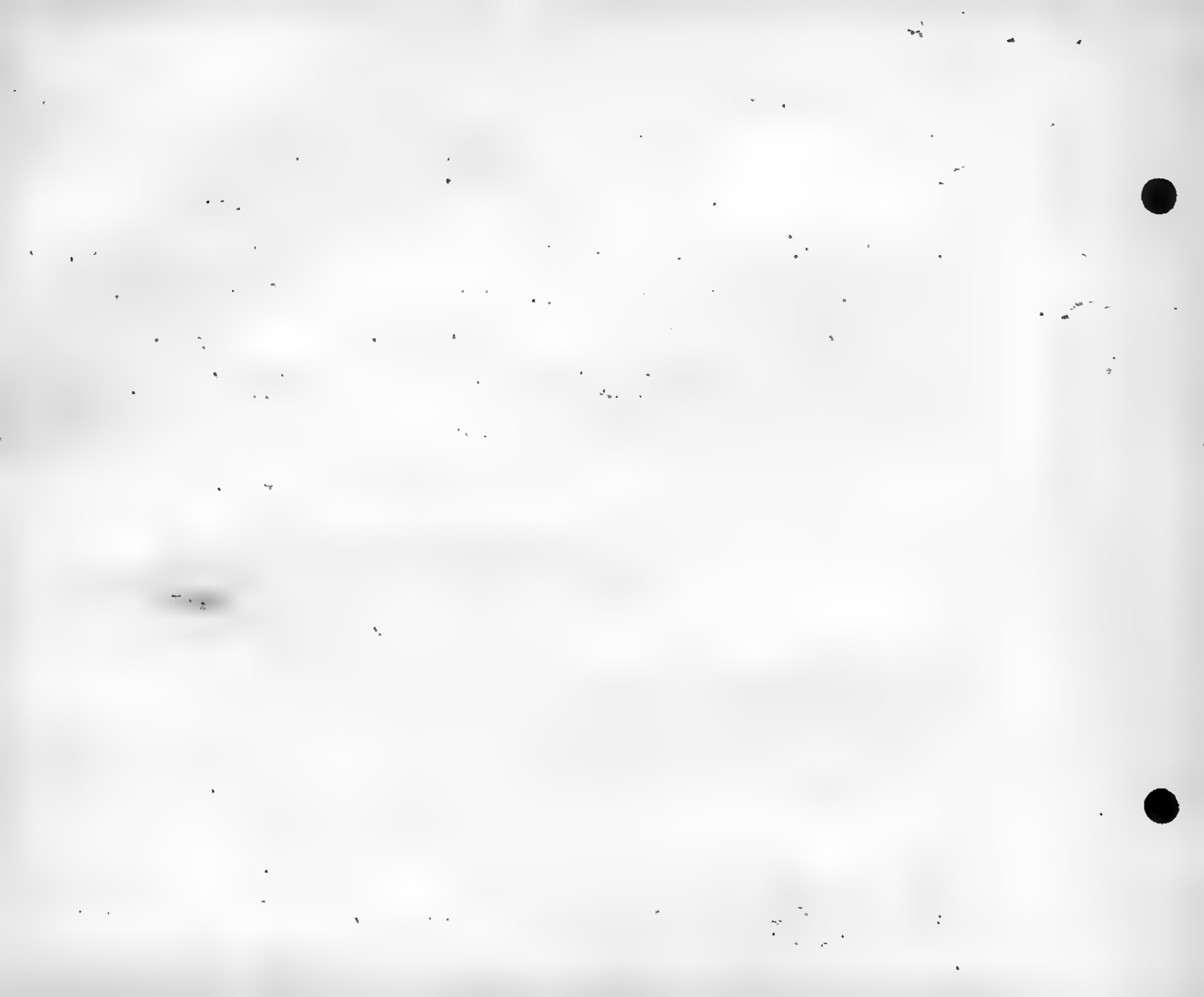
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11930

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED-NAME (Type or print) Edgar A. Gentry | | | 2a. DATE OF DEATH Month 8 Day 8 Year 68 | | 2b. HOUR 10:40 AM |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH July 19, 1904 | | 6. AGE (In years last birthday) 64 YRS | 7. FUNDING YEAR MONTHS DAYS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) TENN | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Prince Georges Md. | | |
| 10. CITY OR TOWN OF DEATH RIVERDALE, MD Mt. Rainier Md. | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Leland Memorial Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired.) ENGINEER | 12b. KIND OF BUSINESS OR INDUSTRY AIR CONDITION | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | 13b. COUNTY Prince Georges | 13c. CITY OR TOWN Mt. Rainier | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET AND NUMBER 3303 Chauncey Pl. | |
| 14. FATHER'S NAME THEODORE | 15. MOTHER'S MAIDEN NAME AUGUSTA | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or, unknown (If yes give war or dates of service) NO | | | |
| 16a. SOCIAL SECURITY NO. 296-07869 | | 16b. INFORMANT MRS. PATRICIA ALLEN Address 6802 24th AV, SEABROOK MD. 20801 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GEN. ARTERIOSCLEROSIS DUE TO, OR AS A CONSEQUENCE OF (c) UNKNOWN | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 11 | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or RFD No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 JUNE, 1968 , to PRESEN , that (I) (we) lost saw the deceased alive on 30 JUNE 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death DR. KEMPE NOTIFIED | | | | | |
| 22b. SIGNATURE C. J. Houmann | DEGREE C. J. HOUMANN | ATTENDING PHYS. <input checked="" type="checkbox"/> | MED. DIRECTOR <input type="checkbox"/> | STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED 9 AUG 1968 |
| 22d. PHYSICIAN'S NAME (Type) C. J. HOUMANN | 22e. ADDRESS RIVERDALE MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 8/12/68 | 23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM | 23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MARYLAND | | |
| 24. FUNERAL DIRECTOR W. W. CHAMBERS CO. | 25a. REC'D BY REGISTRAR W. W. CHAMBERS CO. | 25b. REGISTRAR'S SIGNATURE Charles Judge | DATE AUG 14 1968 | | |



may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11931

339

| | | | |
|--|--|---|---|
| 1 PLACE OF DEATH a. COUNTY <u>Prince Geo.</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Prince Geo</u> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> | | c. LENGTH OF STAY IN 1b <u>13 yrs.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6609 Karlson Ct.</u> | | d STREET ADDRESS <u>6609 Karlson Ct.</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>George</u> | | 4. DATE OF DEATH Month <u>Aug.</u> Day <u>1</u> Year <u>1968</u> | |
| 5 SEX <u>Fe</u> | 6 COLOR OR RACE <u>Wh.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>Oct 26, 1878</u> |
| 9. AGE (In years lost birthday) <u>89</u> yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>N. Carolina.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Robert Correll</u> | | 14. MOTHER'S MAIDEN NAME <u>Emelie Gibbs</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO <u>213-54-8576</u> | |
| 17 INFORMANT <u>Daughter-Corine Gambrell</u> | | Address <u>- same</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis generalized</u> <u>4407</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>general visceral failure</u> DUE TO (c) <u>undet.</u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450: None</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month <u>—</u> Day <u>19</u> Year <u>1968</u> Hour a.m. <u>—</u> p.m. <u>—</u> | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f (City or town) (County) (State) |
| 21 I certify that (I) (the hospital) attended the deceased from <u>August 12, 1967</u> to <u>Aug 1, 1968</u> , that (I) (we) last saw the deceased alive on <u>July 30, 1968</u> , and that death occurred at <u>11:30</u> PM, from the causes and on the date stated above. | | | |
| 22a SIGNATURE <u>William F. Simpson</u> | | 22b DATE SIGNED <u>8/2/68</u> | |
| 22c PHYSICIAN'S NAME (Type) <u>William F. Simpson</u> | | 22d ADDRESS <u>6216 N.H. Ave NE</u> | |
| 23a BURIAL CREMATION REMOVAL (Specify) <u>Burial Aug 5, 1968</u> | 23b DATE THEREOF <u>Aug 5, 1968</u> | 23c NAME OF CEMETERY, OR CREMATORY <u>Fairview</u> | 23d LOCATION (City, town, or county) (State) <u>Spotsylvania, South Carolina</u> |
| 24 FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Talbot</u> | | 25a REC'D BY REGISTRAR DATE <u>AUG 5 1968</u> | |
| 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|------------------------------|--|---|------------------------------------|---|---|--|--------------------------|---|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month 30, Day 1968 Year | | 2b. HOUR P 11:50M | | | |
| James | | | Giles | | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | | |
| Male | | Negro | | May 17, 1915 | | 53 YRS | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| Maryland | | USA | | | | Prince George's | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cheverly | | | Prince Geo. Gen'l Hospital | | | Mail clerk | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Prince George's | | Seat Pleasant | | | | 7284 Geo. Palmer Highway | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Joseph | | | Giless | | | Mary | | | Jones | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | |
| Navy | | | | | | Mary Giles-wife-7284 Geo. Palmer Hgw. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY. | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) SUBARACHNOID HEMORRAGE. | | | | | | | | | | | |
| 4309 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable Rupture of Aneurysm. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (a) (th's hospital) attended the deceased from August 23, 1968, to August 30, 1968, that (b) (we) last saw the deceased alive on August 30, 1968, and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (d) (we) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | |
| P. C. Xavier, M. D. | | | | | | | | | | Aug. 30, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| P. C. Xavier, M. D. | | | | | | Prince Geo. Gen'l Hospital, Cheverly, | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) State | | | |
| Burial | | | 9/4/68 | | Holy Family Catholic Church | | | Woodmoor, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| John T. Stewart | | | | | | SEP 5 1968 | | Charles Judge | | | |
| Stewart Funeral Home-4001 Benning Rd. | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|---|--|---|--|--|------------------------|--|-----------------------|--|-----|--|--|-------------------|--|
| 11933 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 341 | |
| 1 DECEASED-NAME (Type or print) Francis M. Gilroy | | | | | | | | | | 2a. DATE OF DEATH August 19 Day 19 Year 68 | | | | | | | | | | 2b. HOUR M | |
| 3 SEX Male | | | 4 RACE White | | | 5. DATE OF BIRTH Feb. 8, 1899 | | | | 6 AGE (in years last birthday) 69 YRS | | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS HOURS | | MIN | | | | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 COUNTY OF DEATH Pr. Geo. | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Cheverly | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Hosp. | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Bricklayer | | | | 12b KIND OF BUSINESS OR INDUSTRY Construction | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | | | 13b. COUNTY Pr. Geo. | | 13c. CITY OR TOWN Suitland | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 1912 Lakewood St. | | | | | | | | | | | |
| 14. FATHER'S NAME First John Middle A. Last Gilroy | | | | | 15 MOTHER'S MAIDEN NAME First Elizabeth Middle Milstead Last Milstead | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes 1918-1919 | | | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT Frances G. Esmacher Address 1912 Lakewood St. | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) 4104 DUE TO, OR AS A CONSEQUENCE OF acute coronary ischemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Set D. (b) Set D. DUE TO, OR AS A CONSEQUENCE OF Set D. (c) Set D. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b TIME OF INJURY HOUR A.M. Month Day Year 19 P.M. | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18.) | | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 1950 , 19____, to 8/19 , 19 68 , that (I) (we) lost saw the deceased alive on 8/19 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | 22c. DATE SIGNED 8/20/68 | | | | 22d. PHYSICIAN'S NAME (Type) [Signature] | | | | 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 8-22-68 | | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | 23d. LOCATION (City or Town) (County) (State) 4000 Suitland Rd. S. E. | | | | | | | | | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm | | | | ADDRESS Home 4308 Suitland Rd. | | | | 25a REC'D BY REGISTRAR AUG 23 1968 | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11934

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11942

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last NORMAN JENNER, GILROY | | | 2a. DATE OF DEATH Month Day Year AUG 6 1968 | | | 2b. HOUR 8:25 AM | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 8-25-1898 69 | | 6. AGE (in years) 70 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) DASH FC | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince Geo Md | |
| 10. CITY OR TOWN OF DEATH Clinton Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PINEVIEW GARDENS | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BRAKEMAN | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE M.D. | | 13b. COUNTY J36 COUNTY | | 13c. CITY OR TOWN INDIAN HEAD | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER | | 14. FATHER'S NAME First Middle Last Charles JULIAN Gilroy | | 15. MOTHER'S MAIDEN NAME First Middle Last CORA Bell BASTIAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) NO | | 16b. SOCIAL SECURITY NO 213-22-1427 | | 17. INFORMANT Son CHARLES GILROY - Indian Head, Md | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>15 YRS.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>ACUTE PYELONEPHRITIS</u> | | | | | | | |
| 19a. DATE OF OPERATION <u>None</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u> | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> (If either, not by medical examination) <u>None</u> | | 21b. TIME OF INJURY Hour AM Month Day Year <u>None</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>None</u> | | | |
| 21d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> or work <input type="checkbox"/> <u>None</u> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) <u>None</u> | | 21f. LOCATION (Street or R.F.D. No. City or Town County State) <u>None</u> | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>6/28, 1968</u> to <u>present</u> , that (I) <u>(my)</u> last saw the deceased alive on <u>8/6</u> 1968 and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(d)</u> (d.d) <u>(do not)</u> view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Arthur Shaver Jr MD</u> | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 8/6/68 | |
| 22d. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR MD | | | | 22e. ADDRESS 8808 Branch Ave Clinton, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8/10/1968 | | 23c. NAME OF CEMETERY OR CREMATORY Gilroy Family Cemetery | | 23d. LOCATION (City or Town) (County) (State) Doncaster, Maryland | |
| 24. FUNERAL DIRECTOR <u>Michael Funeral Home Inc. - La Plata, Md.</u> | | | | 25a. REC'D BY REGISTRAR DATE AUG 9 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| M. CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|---|--|
| 1 DECEASED-NAME (Type or print) LAST GIVEN | | | | 2a. DATE OF DEATH Month 22 Day 68 Year 1968 | | | | 2b. HOUR 0510 M | | | |
| 3 SEX FEMALE | | 4 RACE CAUCASIAN | | 5 DATE OF BIRTH 4 DEC 1903 | | | | 6 AGE (In years last birthday) 64 YRS. | | 7 UNDER 1 YEAR MONTHS 0 DAYS 0 | |
| 7a BIRTHPLACE (State or foreign country) West Va | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH PRICCE GEORGE'S Md. | | | | | |
| 10. CITY OR TOWN OF DEATH CAMP SPRINGS | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAF Hosp. | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | | 13b COUNTY DEWITT | | 13c CITY OR TOWN DEWITT | | 13d INSIDE CITY, J.M. IS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e STREET AND NUMBER 5517 SEIBY LANE 20024 | |
| 14. FATHER'S NAME First Middle Last GILLESPIE | | | | 15. MOTHER'S MAIDEN NAME First Middle Last CORA ANN VARNEY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO | | | | 16b. SOCIAL SECURITY NO 2344807113 | | | | 17 INFORMANT CHARLES E. Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse 0300 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Gram negative bacteremia DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 4 hours | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b) Hepato renal failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 20 July, 1968 , to 22 Aug, 1968 , that (I) (we) last saw the deceased alive on 22 Aug, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE William E. Palma, Maj USAF MC | | | | 22c. DATE SIGNED 22 Aug 68 | | | | 22d. PHYSICIAN'S NAME (Type) William E Palma Maj USAF MC | | | |
| 22e. ADDRESS Malcom Grow USAF Hospital | | | | 22f. ADDRESS Malcom Grow USAF Hospital | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 8-26-68 | | 23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem. | | | | 23d. LOCATION (City or Town) (County) (State) Arlington, Virginia | | | |
| 24 FUNERAL DIRECTOR Simmons Bros | | | | 25a. REC'D BY REGISTRAR DATE AUG 26 1968 | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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11936

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11944

| | | | | |
|---|---|--|---|--|
| 1. DECEASED NAME (Type or print) Joseph ^{First} Anthony ^{Middle} Gormley ^{Last} | | 2a. DATE OF DEATH Month August Day 6 Year 1968 | | 2b. HOUR 1935 M. |
| 3 SEX Male | 4 RACE White | 5 DATE OF BIRTH 28 July 1920 | 6 AGE (In years last birthday) 48 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a BIRTHPLACE (State or foreign country) Penn. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Prince Georges County | |
| 10 CITY OR TOWN OF DEATH Andrews Air Force Base | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital state street and address) Malcolm Grow USAF Hosp | 12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Mechanic | 12b KIND OF BUSINESS OR OCCUPATION USAF (Ret) | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Prince Georges | 13c CITY OR TOWN Silver Hill | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e STREET AND NUMBER 3835 St. Barnabas Rd. |
| 14. FATHER'S NAME ^{First} Joseph ^{Middle} Anthony ^{Last} | 15 MOTHER'S MAIDEN NAME ^{First} Mary ^{Middle} MONAGHAN ^{Last} | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (If yes give war or dates of service) | | |
| 16b SOCIAL SECURITY NO. 207013981 | 17 INFORMANT James Gormley Address 6206 Surrey Sq. Lane Forestville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4327 IMMEDIATE CAUSE (a) Hypotension DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral emboli DUE TO, OR AS A CONSEQUENCE OF (c) S.B.E. | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RHD & Anemia ? reticulosis | | | | |
| 19a DATE OF OPERATION | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug 5, 1968 , to Aug 6, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug 6, 1968 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death | | | | |
| 22b SIGNATURE Burton Sack | DEGREE CAPT USAF MC | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | 22c DATE SIGNED Aug 6, 1968 | |
| 22d. PHYSICIAN'S BURTON SACK CAPT USAF MC | 22e ADDRESS MALCOLM GROW USAF HOSP ANDREWS AFB | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b DATE 5-9-68 | 23c NAME OF CEMETERY OR CREMATORY ARKINGEN NAT | 23d. LOCATION (City or Town) (County) (State) ARKINGEN LA | |
| 24 FUNERAL DIRECTOR ROBERT F WILHELM | ADDRESS 4508 SWINGHARD RD. SWINGHARD MD | 25a REC'D BY REGISTRAR AUG 12 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

10



11



12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11937

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11045

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|-------|--|---------|---|--|--|-----------------------------------|---------------------------|------|
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR A | | |
| Ila | | | B. | | Graham | August 21 1968 | | | B:20 M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER YEAR MONTHS DAYS | | 8. UNDER 24 HRS HOURS MIN | |
| Female | | White | | March 4, 1893 | | 3 YRS | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Canada | | USA | | | | Prince George's Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Riverdale | | E.Leland Mem. Hosp. | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Pr. George's | | Riverdale | | | | 6104 44th. Pl. | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Jim | | | | | Banning | UNKNOWN. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | | | | |
| NO | | 213-22-4186 | | E.Leland Mem. Hosp. | | 4408 Queensbury Rd. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>Gudden</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 18, 1968</u> to <u>Aug 21, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>L W Malin</u> | | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED <u>8-21-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Lawrence W. Malin, M.D.</u> | | | | | | 22e. ADDRESS <u>4408 Queensbury Rd. Riverdale, Md. 20840</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| <u>BURIAL</u> | | <u>AUG 23 1968</u> | | <u>FORT LINCOLN CEM.</u> | | <u>COLMAR MANOR, MARYLAND</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>W.W. CHAMBERS Co. RIVERDALE, MD.</u> | | | | | | 25a. REG. BY REGISTRAR <u>Aug 26 1968</u> REG. NO. <u>100000</u> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|-----------------------------|--|--|--|--|
| 11933 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 11946 | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Michael Grastataro | | | | | | | | | | 2a. DATE OF DEATH 8 - 17 - 68 Month Day Year | | | | | | | | | | 2b. HOUR 7:20AM | | | | | | | | | | | | | | |
| 3. SEX M | | | | | 4. RACE W | | | | | 5. DATE OF BIRTH 2/28/1890 | | | | | | | | | | 6. AGE (In years lost birthday) 78 YRS | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | |
| 7a. BIRTHPLACE (State or foreign country) foreign born | | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH Prince Georges, Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Glenn Dale | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY unknown | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE T. D. | | | | | | | | | | 13b. COUNTY CD | | | | | 13c. CITY OR TOWN Washington, D.C. | | | | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | | | 13e. STREET AND NUMBER 508 Eye St., N. W. | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last Carlo Grastataro | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Marie | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. 078-10-9761 | | | | | 17. INFORMANT decedent | | | | | | | | | | Address | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden Years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic peripheral vascular disease; left A.K. amputation 1/12/67 due to popliteal artery occlusion | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC) | | | | | | | | | | 21f. LOCATION Street or R.F.D. no City or Town County State | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/31/67 , to 8/17/68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/17/68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Moe Weiss | | | | | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | 22c. DATE SIGNED 8/17/68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | | | | | | | | | 22e. ADDRESS Glenn Dale Hospital, Glenn Dale, Md. | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | | | | 23b. DATE 8/27/68 | | | | | 23c. NAME OF ANATOMICAL SCHOOL Anatomical School | | | | | | | | | | (State) Bethesda MD | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Carl F. Aufmann | | | | | | | | | | ADDRESS | | | | | 25a. REC'D BY REGISTRAR AUG 27 1968 | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | |

GRACE JACINTA

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form M-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| Item 18 Film 405 9-26 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 11939 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) Nattina Green | | | | | | 2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8-20-68 19 2:00am | | 2b HOUR | | | |
| 3 SEX Female | | 4 RACE Negro | | 5 DATE OF BIRTH 3-25-1968 | | 6 AGE (In years last birthday) 4 YRS 26 MONTHS 4 DAYS 26 HOURS MM | | 7c DATE PRONOUNCED DEAD Month 8 Day 20 Year 68 19 4:21 am | | 2d HOUR | |
| 7a BIRTHPLACE (State or foreign country) Wash., D. C. | | | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Prince George's | | | |
| 10 CITY OR TOWN OF DEATH Cheverly | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Infant | | 12b KIND OF BUSINESS OR INDUSTRY ---- | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution) STATE Maryland | | | | 13b COUNTY Prince George's Brandywine | | | | 13c CITY OR TOWN YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Dorsey Road, Rural | | 13e STREET AND NUMBER | |
| 14 FATHER'S NAME James S. Green, Jr. | | | | | | 15 MOTHER'S MAIDEN NAME Bernice B. Brown | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16b SOCIAL SECURITY NO None | | 17 INFORMANT Mr. James S. Green, Jr. Brandywine, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema DUE TO, OR AS A CONSEQUENCE OF Etiology undetermined Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SDII DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 522 X | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b TIME OF INJURY Month, Day, Year 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe MD | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b DATE SIGNED 8-21-68 | | | |
| EXAMINER'S NAME (Type) John Kehoe MD | | | | ADDRESS Riverdale, Md. | | | | ADDRESS (Street, city, town, or county) | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE 8-23-1968 | | 23c NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | | | 23d LOCATION (City or Town) Wash., D. C. (County) Bladensburg Rd., N. E. (State) | | | |
| 24 FUNERAL DIRECTOR MALVAN & SCHEY, INC. 424 "R" St., N. W. | | | | ADDRESS Wash., D.C. | | | | 25a REC'D BY REGISTRAR AUG 26 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV

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|---|-------------------------|---|---|--|---|
| 11840 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item 23a Film C | | 11848 | |
| 1. DECEASED-NAME (Type or print) BETIE W GRIFFS | | | 2a. DATE OF DEATH Month August Day 10 Year 1968 | | 2b. HOUR 2:05 PM |
| 3. SEX FEMALE | 4. RACE White | 5. DATE OF BIRTH 6/2/1899 | | 6. AGE (In years last birthday) 69 YRS. | 7. UNDER 1 YEAR MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (State or foreign country) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH PRINCE GEORGES Md | |
| 10. CITY OR TOWN OF DEATH LANHAM | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MAGNOLIA GARDENS HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md. | | 13b. COUNTY P.G. | 13c. CITY OR TOWN LANHAM | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 7227 AIDMORE LA. |
| 14. FATHER'S NAME First CHARLES Middle H. Last WILLIAMS | | 15. MOTHER'S MAIDEN NAME First IDA Middle R. Last BRIGGS | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, NO (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 217-48-8121 | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) C.A. of GALLBLADDER 1560 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/12 , 19 68 , to 8/10 , 19 68 , that (I) (we) last saw the deceased alive on 8/10 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Leon Levitsky | | | | 22c. DATE SIGNED 8/10/68 | |
| 22d. PHYSICIAN'S NAME (Type) LEON LEVITSKY (M.D.) | | | | 22e. ADDRESS Magnolia Gardens Home | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8/14/68 | | 23c. NAME OF CEMETERY OR CREMATORY St. Lincol | |
| 24. FUNERAL DIRECTOR W.W. Chambers Co. | | 24b. ADDRESS 580 CLEVELAND AVE., RIVERDALE, MD. | | 25a. REC'D BY REGISTRAR Charles Judge | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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11944

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11949

| | | | | | | | | | | | |
|---|--|---|---|---|---|------------------------------|--|----------------------------|----------|--|------|
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| John | | | | Grilles | | Aug. Month 19, Day 1968 Year | | | 6:25 PM | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| Male | Caucasian | 10/18/85 | | 82 YRS. | | MONTHS DAYS | | HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| Greece | U S A | | | Prince George's Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Cheverly | Prince Geo. Gen'l Hospital | | Retired Cabinet Maker | | U S Government | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) | 13b. CITY OR TOWN | 13c. INSIDE CITY LIMITS? | 13d. STREET AND NUMBER | | | | | | | | |
| Maryland | Prince George's | Bladensburg | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 5100 Tilden Rd. | | | | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Steve Grilles | | | | | | Helen | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | |
| no | | | 577 56 4492T | | Elsie M Grilles | | Bladensburg, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> | | | | | | | | | | | |
| 4127 DUE TO, OR AS-A CONSEQUENCE OF (b) <u>Intermittent Heart Disease</u> | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 4200 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 2, 1962 to Aug 22, 1968, that (I) (we) lost saw the deceased alive on Aug 19, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | | | |
| A. Deitz | | 8 20 68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| Aaron Deitz, M. D. | | Prince George's Plaza, Hyattsville, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | Aug 22, 1968 | | Ft Lincoln Cemetery | | Colmar Manor Pro Geo Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| F. Gasch's Sons | | | | Hyattsville, Md | | DATE AUG 22 1968 | | Charles Judge | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and file any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | |
|---|--------|--|--|---|--|-----------------------------------|--|--|--|--------|--|---|--|--------|--|---------------------------|--|
| 1 DECEASED-NAME (Type or Print) | | First | | Middle | | Last | | 2a DATE KNOWN OF DEATH | | Month | | Day | | Year | | 2b HOUR | |
| Phillip Andrew Grimes | | | | | | | | 8 31 1968 | | | | | | | | 6:00 PM | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | | 6 AGE (in years last birthday) | | 7 IF UNDER 24 HRS | | 8 MONTHS | | 9 DAYS | | 10 HOURS | | 11 MIN | | 2c DATE PRONOUNCED DEAD | |
| M | W | 10 Aug. 1907 | | 61 YRS | | | | | | | | | | | | Month 9 Day 31 Year 19 68 | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | Prince George Md | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Cheverly | | Prince George | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET AND NUMBER | | | | | | | | | | | |
| DC. Md. | | Washington | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1436 18th pl. S.E. | | | | | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last | | | |
| Andrew Grimes | | | | | | | | Gertrude A. Grimes (Wife) | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT | | ADDRESS | | | | | | | | | |
| | | | | | | Gertrude A. Grimes (Wife) | | 1830 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Crushing injury of chest and head</u> | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | | | |
| (b) <u>DUE TO, OR AS A CONSEQUENCE OF</u> | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| 9121 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? | | | | | | | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| | | | | 6:00 PM 8 31 19 68 | | | | Crushed under overturned tractor | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | |
| | | | | Farm | | | | Aquasco Prince George Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | John Kehoe, M.D., Riverdale | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 9-2-68 | | | | | |
| | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | | | |
| | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REG STRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| James J. Jones | | | | | | | | SEP 4 1968 | | | | J. Charles Judge | | | | | |

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11943

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11951

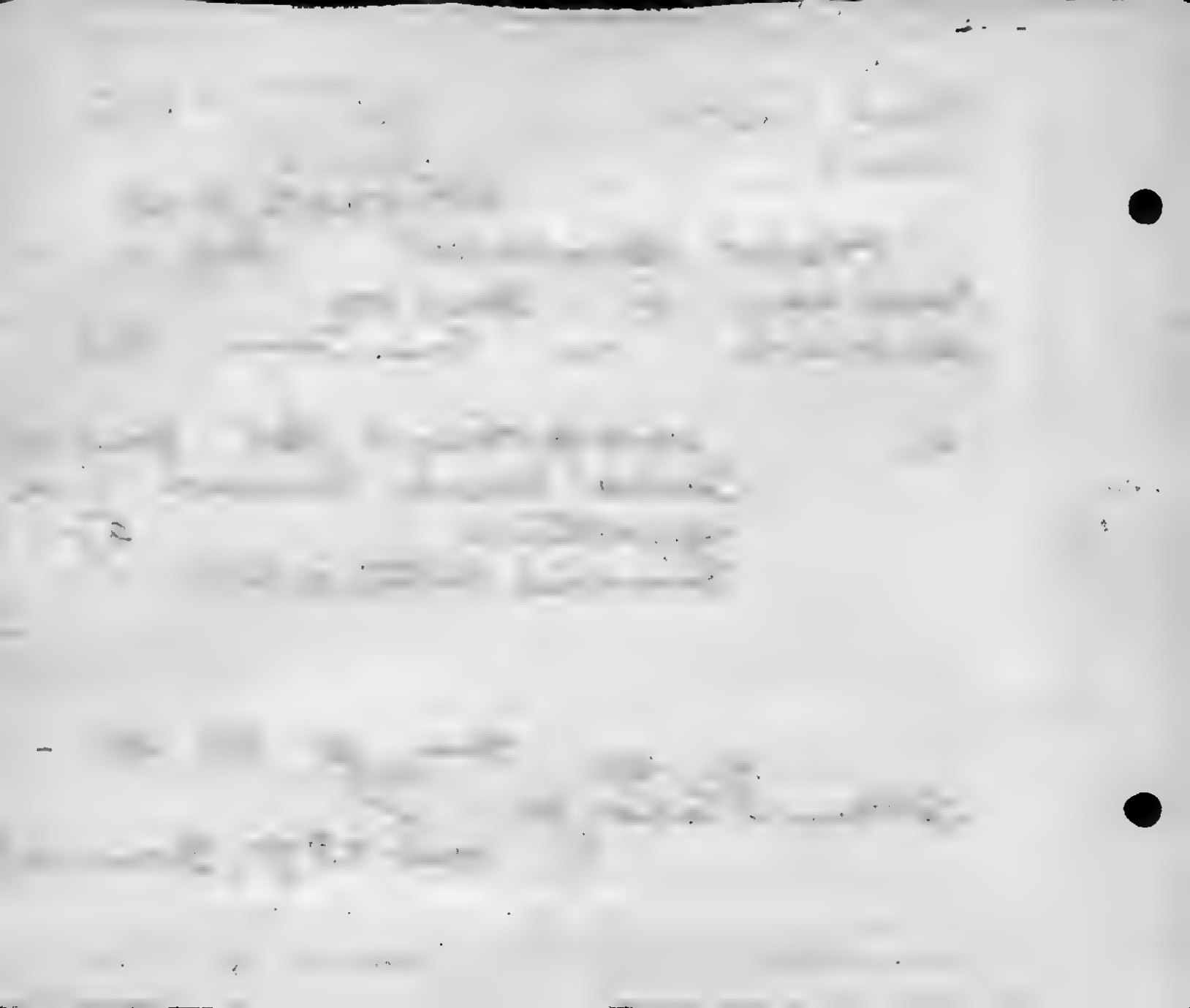
| | | | | | | | | | | | | | | |
|---|--------|-----------------------------|--|---------------|------|---|-----|---------------------------|---|--|---------|-----------------------------------|--|--|
| 1 DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | | Month Day Year | | | 2b HOUR | | |
| Katherine A Guasp | | | | | | 8 21 19 68 | | | | | | 4:15 p M | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | IF UNDER YEAR | | IF UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD | | | 2d HOUR | | | |
| F | W | 26 Dec., 1886 | 81 YRS | MONTHS | DAYS | HOURS | MIN | Month 8 Day 21 Year 19 68 | | | same M | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | | | | |
| Washington D C | | U S A | | WIDOWED | | DIVORCED | | Prince George Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| Cheverly | | | Prince George Hosp | | | Housewife | | | Home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY, APTS? | | | 13e. STREET AND NUMBER | | |
| Md. | | | Prince George | | | Riverdale | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 5006 Rittenhouse St., | | |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b SOCIAL SECURITY NO | | | 17 INFORMANT | | |
| John Sullivan | | | Johanna Fuller | | | no | | | | | | Katherine A Dockendorf | | |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b), and (c)) | | | 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | 10 days | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Bronchopneumonia and | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| Arteriosclerotic heart disease | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| Fracture of Pelvis | | | | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> | | | 21b TIME OF INJURY Month, Day, Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| CAUSE OF DEATH | | | 1:30 p.m. 7 24 68 | | | Fell in living room of home. | | | | | | | | |
| 21d INJURY OCCURRED | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No | | | City or Town | | | County | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | Home | | | 5006 Rittenhouse St. | | | Riverdale P.G. | | | Md. | | |
| 22a. I certify that I took charge of the remains described above, held an | | | Autopsy <input type="checkbox"/> | | | Inspection <input checked="" type="checkbox"/> | | | Inquiry <input checked="" type="checkbox"/> | | | and in my opinion | | |
| death resulted from: | | | Natural cause <input type="checkbox"/> | | | Accident <input checked="" type="checkbox"/> | | | Suicide <input type="checkbox"/> | | | Homicide <input type="checkbox"/> | | |
| | | | Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | ASSISTANT MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | John Kehoe, M.D., Riverdale | | | DEPUTY MEDICAL EXAMINER | | | 8-22-68 | | | | | |
| | | | ADDRESS (Street, city town or county) | | | | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) | | | (County) (State) | | |
| Burial | | | Aug 24, 1968 | | | Mt Olivet Cemetery | | | Washington D. C. | | | | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| F. Gasch's Sons | | | Hyattsville, Md. | | | DATE AUG 26 1968 | | | Charles Judge | | | | | |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11968
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

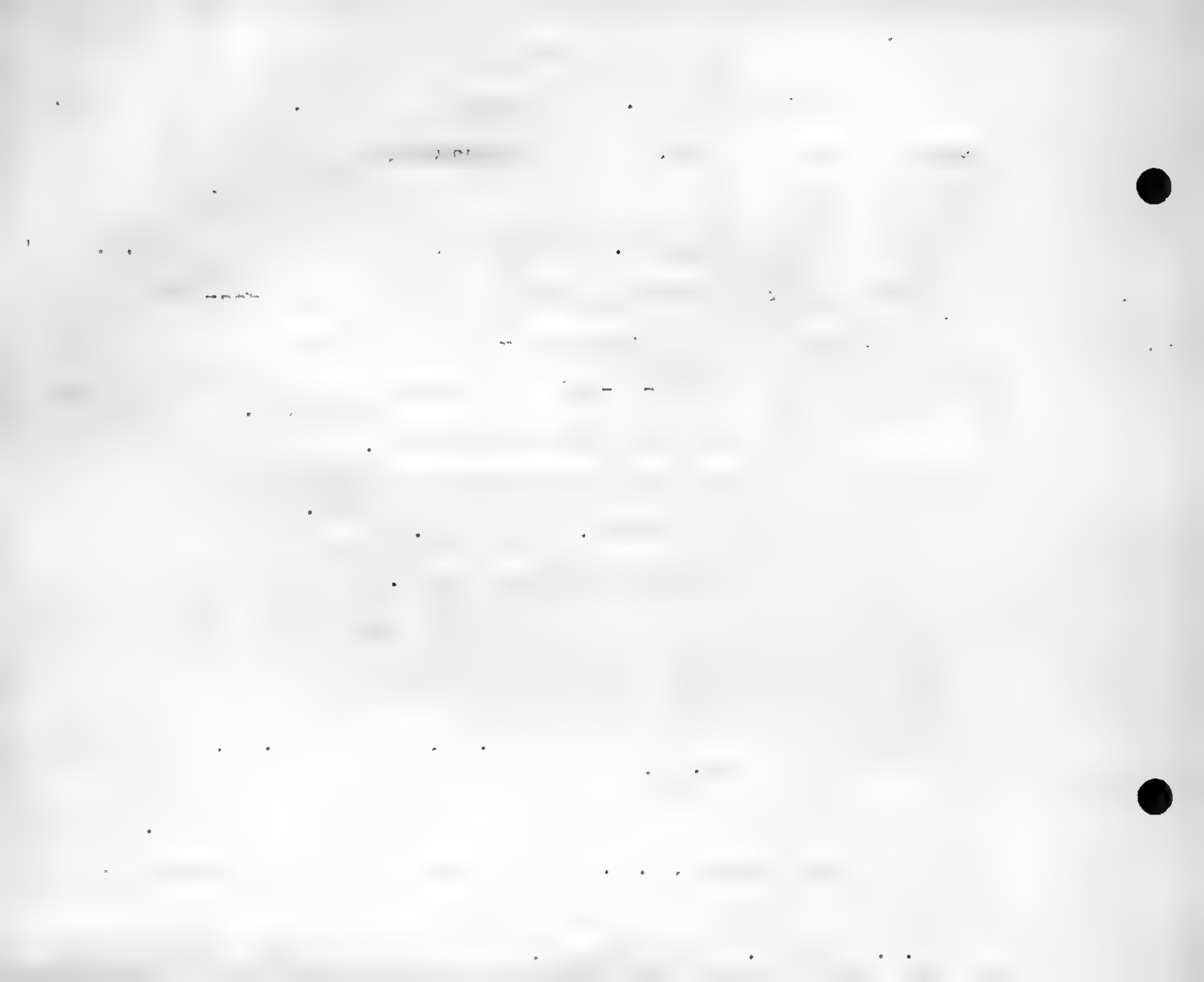
| | | | |
|--|------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Prince Georges MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY P.G. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowie | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS 6th + Chestnut sts | |
| 3. NAME OF DECEASED (Type or print) Helen Hanson Ella Hall | | 4. DATE OF DEATH Aug 1 1968 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec 7 1893 74 yrs. |
| 9. AGE (In years last birthday) 74 | | 10. IF UNDER 1 YEAR Months Days 10. IF UNDER 24 HRS Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State or foreign country) Prince Georges | | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13. FATHER'S NAME Unknown | | 14. MOTHER'S MAIDEN NAME Unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 216-58-505 | |
| 17. INFORMANT Address Helen L. Hall | | Bowie Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident | | | |
| (b) Hypertension | | | |
| (c) Generalized Arteriosclerosis | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331x | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 1968 to 8/1 1968 that (I) (we) last saw the deceased alive on 8/1 1968, and that death occurred 12:15 PM from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Dr. Henry G. Caise Jr. M.D. | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS 13008 9th St, Bowie, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 7-5-68 | |
| 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | 23d. LOCATION (City, town or county) Prince George, Md. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John T. Rhines | | 25a. REC'D BY REGISTRAR AUG 5 1968 | |
| 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|---|--|-----------|--|-------------------|--|--|---------------------------------|--|--|--|----------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR P M | | | | |
| Dorothy | | | M. Hammer | | | Aug. 27, 1968 | | | 12:10 P | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | |
| Female | | Caucasian | | February 22, 1901 | | | 67 YRS. | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md. | |
| Pennsylvania | | | | | | | | | Prince George's | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Cheverly | | | Prince Geo. Gen'l Hospital | | | Accountant | | | U.S. Gov't | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY, JMW, 157? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER | |
| Maryland | | | Prince George's | | | Lanham | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | Princess 6160 Prince Garden Pkwy | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | |
| Jacob Willcher | | | Kathryn Cohen | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | | | |
| no | | | 578-32-8115 | | | Dea Hammer | | | 6160 Princess Pkwy | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Acute congestive heart failure. | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Stenosing coronary artery disease with healing | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction. | | | | | | | | | | | | | |
| Endocarditis, aortic valve. | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| Generalized arteriosclerosis. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| 22a. I certify that (s) (this hospital) attended the deceased from Aug. 27, 1968, to Aug. 27, 1968, that (s) (we) last saw the deceased alive on Aug. 27, 1968, and that in (s) (our) opinion death occurred on the date and hour and from the causes stated above. (s) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>R. S. Bharati</i> | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED Aug. 27, 1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Saroja Bharati, M. D. | | | | | | 22e. ADDRESS Prince George's General Hospital, Cheverly | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 8/30/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l | | | 23d. LOCATION (City or Town) (County) Suitland, Maryland Maryland | | | | |
| 24. FUNERAL DIRECTOR The S.H. Hines Co. Washington, D. C. | | | | | | 25a. REC'D BY REGISTRAR DATE AUG 30 1968 | | | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i> | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

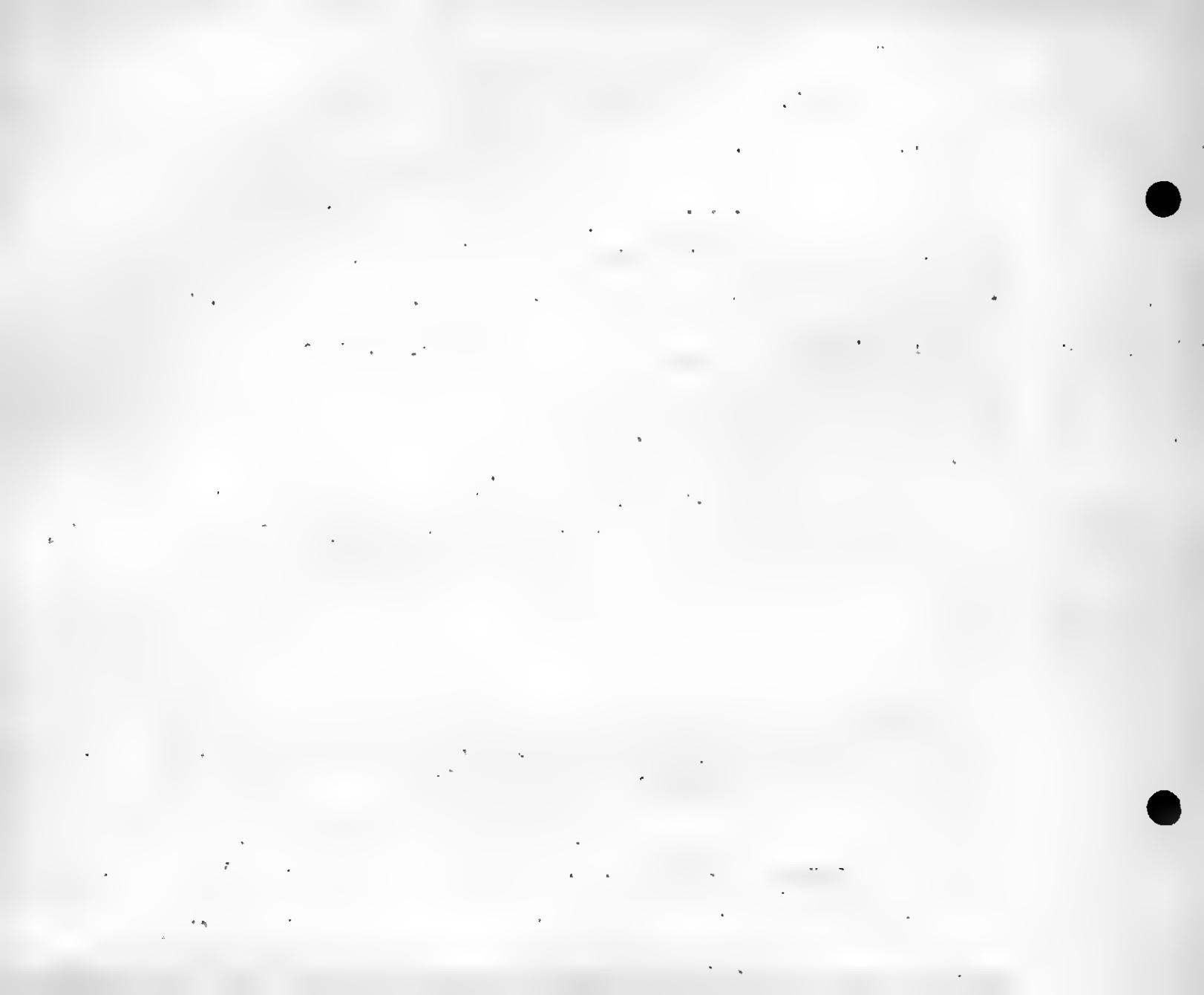
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11946 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 11354 | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|------------------------------|--|--|--|--|---------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | |
| First Middle Last Nellie C. Handiboe | | | | | | | | | | Month Day Year August 26, 1968 | | | | | | | | | | 7:30PM | | | | | | | | | |
| 3. SEX Female | | | 4. RACE Caucasian | | | 5. DATE OF BIRTH Feb. 17, 1881 | | | 6. AGE (In years last birthday) 87 YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS HOURS MIN | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Prince George's Md. | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Prince George's | | | 13c. CITY OR TOWN Hyattsville | | | 13d. INSIDE CITY LIM 757 YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 5009 40th Place | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last EDGAR COLLINS | | | 15. MOTHER'S MAIDEN NAME First Middle Last SARAH E. TALBOT | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No | | | 16b. SOCIAL SECURITY NO NONE | | | 17. INFORMANT MISS KATHERINE HANDIBOE SAME AS DECEASED | | | Address | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Massive acute hemorrhagic infarction, right cerebral hemisphere. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Infarction, early of the small intestine, segmented | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Stenosing coronary artery disease. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | | | | | | | | | |
| 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. WHERE OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) | | | | | | | | | | | | | | | | | | | |
| 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Spring, 1965 , to August 26, 1968 , that (I) (we) last saw the deceased alive on August 26, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (saw) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Barry Rosenberg | | | | | | | | | | 22c. DATE SIGNED August 28, 1968 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Barry Rosenberg, M. D. | | | | | | | | | | 22e. ADDRESS 6501 Landover Rd., Cheverly, Md. 20785 | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL | | | | | | | | | | 23b. DATE 8-29-1968 | | | | | | | | | | | | | | | | | | | |
| 23c. NAME OF CEMETERY OR CREMATORY CONGRESSIONAL CEM | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR W. W. Chambers Co. Riverdale, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR AUG 29 1968 | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|-------------------------|---|---|--|---|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Baby Boy Harden | | | | | | August Month 2, Day 1968 ^{or} | | 5:15A ^M | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | F UNDER 1 YEAR MONTHS DAYS | |
| Male | | Negro | | July 7, 1968 | | YRS. 25 | | F UNDER 24 HRS. HOURS MIN | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Prince George's Md | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | Prince George's Hospital | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| Maryland | | Prince George's | | Jefferson Hgts. | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 6505 K St., NE | |
| 14. FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| William Harden | | | Betty Jean Waiters | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT Address | | | | |
| | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory distress syndrome</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>No - metabolic acidosis No - heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Severe asthma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>773</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 7, 1968</u> , to <u>August 2, 1968</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 2, 1968</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (d.d.) (we) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED |
| Bernardo Alvarado, M. D. | | | | | | | | | Aug 3, 1968 |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| | | | | | Prince George's General Hospital, Cheverly | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| | | 8/17/68 | | Prince Geo. General Hosp. | | Cheverly, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| HARRY W. PENN, JR. | | | | | ADMINISTRATOR | | DATE AUG 20 1968 | | Charles Judge |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11048

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11:56

| | | | | | | | | | | | | |
|---|--------------------|---|--|---|--------------------------------|---|--|--|---|--|--|--|
| 1 DECEASED NAME (Type or Print) Tamara | | | First Middle Last Harley | | | 2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8 3 1968 | | | 2b HOUR 5:40 P M | | | |
| 3 SEX F | 4 RACE W | 5. DATE OF BIRTH 10 Jan., 48 | | 6 AGE (in years last birthday) 20 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. | 2c DATE PRONOUNCED DEAD Month 8 Day 3 Year 1968 | | | 2d HOUR 5:55 P M | | |
| 7a BIRTHPLACE (State or foreign country) New York | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Prince George Md | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Student | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE N. Y. | | | 13b COUNTY N | | | 13c CITY OR TOWN New York | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 18 E. 68th St., Apt 5-A | | |
| 14 FATHER'S NAME Andre | | | First Middle Last Harley | | | 15. MOTHER'S MAIDEN NAME Natalie | | | First Middle Last Hourvitch | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16b SOCIAL SECURITY NO (If yes give war or dates of service) N.A. | | | 17 INFORMANT Frank E. Campbell ADDRESS F.H. 81st & Madison Ave NYC | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Laceration of brain 816.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Skull fracture DUE TO, OR AS A CONSEQUENCE OF (c) Trauma-auto accident | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2224 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a EXTERNAL CAUSE WAS PR MARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. 5:35 am 8 3 1968 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Passenger in car which overturned. | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Baltimore Wash., Prkwy | | | | 21f. LOCATION Street or R.F.D. Na City or Town County State Greenbelt Prince George Co Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b DATE SIGNED 8-4-68 | | | | |
| EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale | | | | ADDRESS (Street, city, town, or county) | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Removal | | | 23b DATE 8-5-68 | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) NEW YORK CITY N.Y. | | | |
| 24 FUNERAL DIRECTOR Joseph Gawlers Sons | | | | | | ADDRESS 5130 Wisc. Ave. N. W. Washington D. C. | | | 25a. REC'D BY REGISTRAR DATE AUG 7 1968 | | 25b REGISTRAR'S SIGNATURE J. Charles Judge | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|------------------|--|--------------------------------|---|---|--------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | | |
| Donald W Harrell | | | | | | Month Day Year | | Hour | | | |
| 3 SEX | | | 4. RACE | | 5. DATE OF BIRTH | | 6 AGE (in years last birthday) | | 7 UNDER 1 YEAR | | |
| M | | | W | | 18 Dec., 1945 | | 22 | | MONTHS DAYS HOURS MIN | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED | | 9 COUNTY OF DEATH | | 2c DATE PRONOUNCED DEAD | |
| Oklahoma | | | USA | | | NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Prince George | | Month 8 Day 11 Year 1968 | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | 2d HOUR | |
| Camp Springs | | | Andrews Air Force Hosp. | | | U.S. Navy | | USN | | 5:10 PM | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS | | 13e STREET AND NUMBER | |
| Colorado | | | Comanche | | | City | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 8131 Pontiac St. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 16b SOCIAL SECURITY NO. | | |
| THOMAS R HARPELL | | | BARBARA J PALMER | | | YES <input checked="" type="checkbox"/> (If yes give year or dates of service) | | | 524 52 2924 Navy Casualty | | |
| 17 INFORMANT | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | |
| ADDRESS | | | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | 20. AUTOPSY? | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| Andrews AFB, Md | | | Lacerations of brain | | | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| | | | Multiple skull fractures | | | | | | | | |
| | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| | | | Trauma-auto accident | | | | | | Min. | | |
| | | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 5:05 PM 8 11 1968 | | | 5100 Block-Suitland Road-Car overturned | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No. | | | City or Town | | |
| Street | | | Suitland Road | | | Camp Springs P.G. | | | Md. | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. | | | Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | 22b DATE SIGNED | | | | | |
| ACTUAL SIGNATURE | | | John Kehoe, M.D., Riverdale | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | |
| BURIAL | | | 8-16-68 | | | | | | DENVER COLORADO | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a REC'D BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | |
| W.W. Chambers Co | | | 1400 Chapin St N.W. | | | DATE AUG 16 1968 | | | J Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Continued on page 2 of 2

11950

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 2a Film 3403

CERTIFICATE OF DEATH

1958

| | | | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME (Type or print) <i>Thomas</i> | | | First Middle Last <i>Haw, Sr.</i> | | | 2a. DATE OF DEATH Month Day Year <i>August 2 1968</i> | | | 2b. HOUR M <i>AM</i> | | | | | |
| 3 SEX <i>Male</i> | | | 4 RACE <i>White</i> | | | 5. DATE OF BIRTH <i>Nov. 25, 1892</i> | | | 6. AGE (In years last birthday) YRS MONTHS DAYS HOURS M IN. <i>75</i> | | | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>England</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Prince Georges</i> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Hyattsville, Maryland</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>U. S. W. Highway,</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Ret. Telegrapher</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Weather Bureau</i> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) - STATE <i>Maryland</i> | | | 13b. COUNTY <i>Prince Georges</i> | | | 13c. CITY OR TOWN <i>Hyattsville</i> | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER <i>1807 E.W. Highway,</i> | | |
| 14. FATHER'S NAME First Middle Last <i>Charles</i> | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Elizabeth Iverson</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <i>Yes</i> | | | 16b. SOCIAL SECURITY NO. (If yes give year or dates of service) <i>577-14-7163</i> | | | 17. INFORMANT Address <i>Mrs. Mildred Haw 1807 E.W. Highway, Hyattsville, Md.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Arterio-sclerotic Heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerosis, genl.</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>10 yrs (est.)</i> <i>10 " +</i> | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <i>4201</i> <i>Myocardial Failure</i> | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>—</i> , 19 <i>50</i> , to <i>Aug. 2, 1968</i> , that (I) <i>(we)</i> lost saw the deceased alive on <i>Feb.</i> , 19 <i>68</i> , and that in (my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(we)</i> (did) <i>(did not)</i> view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Philip H. Varner,</i> | | | | | | DEGREE MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED <i>8-2-68</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Philip H. Varner, MD</i> | | | | | | 22e. ADDRESS <i>10620 Ga., Ave., Wheaton, Md.</i> | | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i> | | | 23b. DATE <i>Aug. 5, 1968</i> | | | 23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>Bladensburg, P. G. Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc., 8434 Ga., Ave., S.S.</i> | | | | | | 25a. REC'D BY REGISTRAR DATE <i>AUG 6 1968</i> | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| 11951 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 11959 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First MARY Middle U Last HAWKINS | | | | | | | | | | Month 8 Day 28 Year 68 | | | | | | | | | | 11:00 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX F | | | | | | | | | | 4. RACE N | | | | | | | | | | 5. DATE OF BIRTH 7-2-81 | | | | | | | | | | 6. AGE (In years last birthday) 87 YRS | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) U.S.A | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Pr. George Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Clinton | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pineview Gardens House | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Wife | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE Md | | | | | | | | | | 13b. COUNTY CHARLES | | | | | | | | | | 13c. CITY OR TOWN LA PLATA | | | | | | | | | | 13d. INS DE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER Rt 2 | | | | | | | | | |
| 14. FATHER'S NAME First GONZEY Middle GREEN Last REEDER | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First ANNIE Middle REEDER Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO | | | | | | | | | | 16b. SOCIAL SECURITY NO None | | | | | | | | | | 17. INFORMANT Address Annie Smothers-Daughter - Newburg, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | (b) Congestive Heart Failure | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | (c) Coronary Artery Disease | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 1, 1968, to Aug. 29, 1968, that (I) (we) last saw the deceased alive on Aug. 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Alfred R. Lapen, M.D. | | | | | | | | | | 22c. DATE SIGNED 8/29/1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Alfred R. Lapen, M.D. | | | | | | | | | | 22e. ADDRESS Clinton, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMAT., OR REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE 9/2/1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) Pomfret, Maryland (County) (State) | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Michael Funeral Home, Inc. La Plata, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR SEP 4 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11952 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------|--|--|--|--|--|--|--|--|--|-----------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|-----|--|--|--|--|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print) | | | | | | | | | | First Middle Last | | | | | | | | | | 2a DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Helen Yvonne Hill | | | | | | | | | | | | | | | | | | | | Aug. 5, 1968 | | | | | | | | | | DOA 8:45A ^M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5 DATE OF BIRTH | | | | | | | | | | 6 AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR | | | | | | | | | | IF UNDER 24 HRS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Female | | | | | | | | | | Caucasian | | | | | | | | | | MAY 29, 1918 | | | | | | | | | | 50 YRS. | | | | | | | | | | MONTHS | | | | | | | | | | DAYS | | | | | | | | | | HOURS | | | | | | | | | | M N | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9 COUNTY OF DEATH | | | | | | | | | | Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DISTRICT OF COL | | | | | | | | | | U.S. | | | | | | | | | | | | | | | | | | | | Prince George's | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cheverly | | | | | | | | | | DOA Prince Geo. Gen'l Hospital | | | | | | | | | | HOUSEWIFE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Prince George's Kentland | | | | | | | | | | | | | | | | | | | | YES | | | | | | | | | | 7206 Forest Road | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14 FATHER'S NAME | | | | | | | | | | First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CLAUDE MARION | | | | | | | | | | | | | | | | | | | | UNKNOWN | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | | | | | | | | | (If yes give war or dates of service) | | | | | | | | | | 16b SOCIAL SECURITY NO | | | | | | | | | | 17 INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | | | | | | | | | | | 577-28-1058 | | | | | | | | | | WILLIAM W. HILL | | | | | | | | | | SAME AS #13 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) | | | | | | | | | | PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | Pulmonary Failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | Pulmonary Emphysema | | | | | | | | | | Years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | Bronchitis | | | | | | | | | | Years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | Malnutrition | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from _____, 19____, to Aug. 5, 1968, that (I) (the) last saw the deceased alive on _____, 19____, and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (the doctor) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | | | | | THOMAS N. CARTER M.D. | | | | | | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | | | 22c DATE SIGNED 8/7/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) | | | | | | | | | | THOMAS NELSON CARTER | | | | | | | | | | 22e ADDRESS | | | | | | | | | | 1835 EYE ST. N.W. D.C. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b DATE | | | | | | | | | | 23c NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BURIAL | | | | | | | | | | 8-10-1968 | | | | | | | | | | CEDAR HILL | | | | | | | | | | SUITLAND MD | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | W. W. CHAMBERS, Co. Riverdale, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | DATE AUG 8 1968 | | | | | | | | | | J. Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11053

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11061

| | | | | | | | | | | | | |
|--|--------|-----------------|--------------------------------|--|--|---|--|---|----------------------|--|----------|-----------------------------------|
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8-17-68 | | | 2b. HOUR 197:20pm | | | |
| Percy | | | Carl | | | Holmes | | | | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c. DATE PRONOUNCED DEAD Month Day Year | | | 2d. HOUR | |
| Male | Negro | 10/17/78 | 89 YRS | | | | | 8 17 68 | | | 7:41pm | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | |
| | | | USA | | | | | | Prince George's Md | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cheverly | | | | Prince George Hospital | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| Maryland | | | | Prince George Highland Park | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1110 69th. Place | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| unknown | | | | unknown | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | |
| | | | | | | | | Highland Clement Martin-1108 69th Pl. Park | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 2 yrs. | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 421 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | |
| EXAMINER'S NAME (Type) | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 8-18-68 | | | | |
| John Kehoe MD Riverdale, Md. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | | 8/21/68 | | Lincoln Memorial Cemetery Maryland | | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. RECD BY REGISTRAR | | 25b. REG. STAMP SIGNATURE | | | | |
| Stewart Funeral Home-4001 Benning Rd., | | | | | | E. AUG 22 1968 | | Judge | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit, then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11954 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 1968 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--------------------|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|-----------------------------|--|--|--|--|---------------------------|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | First DELLA | | | | | Middle C. | | | | | Last HOOD | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | Month AUG | | | | | Day 9 | | | | | Year 1968 | | | | | 12:30 AM | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | F | | | | | 4. RACE | | | | | WHITE | | | | | 5. DATE OF BIRTH | | | | | 7-20-97 | | | | | 6. AGE (In years last birthday) | | | | | 71 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | IF UNDER 24 HRS HOURS MIN | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | W. VA. | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | USA | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH | | | | | | | | | | PRINCE GEORGE Md | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | CLINTON | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | PINEVIEW GARDENS | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | RETIRED | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | Eng. | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | | | MD. | | | | | 13b. COUNTY | | | | | P.G. | | | | | 13c. CITY OR TOWN | | | | | MARLOW HTS. | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | | | | | 5939 28th AVE. SE | | | | | | | | | |
| 14. FATHER'S NAME | | | | | First General Lee | | | | | Middle Calbert | | | | | Last Samantha | | | | | 15. MOTHER'S MAIDEN NAME | | | | | First Samantha | | | | | Middle Cain | | | | | Last | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown | | | | | NO | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | NIECE | | | | | Address | | | | | SAME | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | IMMEDIATE CAUSE (a) 402X HYPERTENSIVE HEART DISEASE 8 MONTHS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | | | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 442X SEVERE GENERALIZED ARTHRITIS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | HOUR AM Month Day Year P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from JAN 20, 1968 to 8/9, 1968, that (I) (we) last saw the deceased alive on 8/8, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BRUNO KOLEGA | | | | | | | | | | | | | | | 8/9/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | 4400 CAMP RD. TEMPLE HILLS - Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b. DATE | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | 10-10-68 | | | | | Temple Hills Cemetery | | | | | Temple Hills - Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | |
| Simmons Bros. | | | | | | | | | | | | | | | DATE AUG 12 1968 | | | | | | | | | | | | | | | J. Charles Judge | | | | | | | | | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If possible, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal in any event, within 72 hours after death.)

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|---|---|--|--|--|---|--|--------------------------------|--|--|--|--|--|--|--|--------------|--|
| 11955 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 11963 | |
| 1 DECEASED NAME (Type or print) First Middle Last EDNA M HORNER | | | | | | | | | | 2a DATE OF DEATH Month Day Year 8 4 68 | | | | | | | | | | 2b HOUR M | |
| 3. SEX FEMALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH 5-3-91 | | | 6. AGE (In years last birthday) 77 YRS. | | | 7. UNDER 1 YEAR MONTHS DAYS | | | 8. UNDER 24 MRS. HOURS MIN | | | | | | |
| 7a BIRTHPLACE (State or foreign country) PA | | | 7b CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH PRINCE GEORGES Md | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH CLINTON | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PINEVIEW GARDENS | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Office | | | 12b. KIND OF BUSINESS OR INDUSTRY US Gov't | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived at institut an admission) STATE MD/1 Washington, D.C. | | | 13b CITY OR TOWN WASH. DC | | | 13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER 2120 16th ST NW | | | | | | | | | | | | |
| 14 FATHER'S NAME First Middle Last Curtis E. Horner | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Annie Richardson | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> or unknown | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. - | | | 17 INFORMANT Nursing Home Records Address | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 4409 DUE TO, OR AS A CONSEQUENCE OF CONGESTIVE HEART FAILURE (b) <u>ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4500 | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l by medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-1, 1968, to 8-4, 1968, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE Craig S. Adelman | | | DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c DATE SIGNED 8/4/1968 | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e ADDRESS | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE 8-7-68 | | | 23c NAME OF CEMETERY OR CREMATORY Grandview Cemetery | | | 23d LOCATION (City or Town) (County) (State) Cambria County, Pa. | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home 4308 Suitland Rd. Suitland, Maryland | | | | | | 25a REC'D BY REGISTRAR DATE AUG 12 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy of pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

11956

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11964

| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH a. COUNTY <u>Prince George's</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>D.C.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cheverly</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Prince George's General</u> | | d. STREET ADDRESS <u>2501 N. ST. S.E.</u> | |
| 3 NAME OF DECEASED (Type or print) <u>ROSA L. Hostetter</u> | | 4 DATE OF DEATH <u>8-24-68</u> 19 <u>68</u> | |
| 5 SEX <u>F</u> | 6 COLOR OR RACE <u>W</u> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>4-16-16</u> |
| 9 AGE (in years last birthday) <u>52</u> yrs | | 10 UNDER 1 YEAR <u>8</u> Months <u>24</u> Days <u>16</u> Hours <u>52</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIST</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>FEDERAL LITHOGRAPH</u> | |
| 11 BIRTHPLACE (County & State or foreign country) <u>VIRGINIA</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>CRAIG W. BANE</u> | | 14. MOTHER'S MAIDEN NAME <u>ELIZABETH. REED</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>579182026</u> | |
| 17. INFORMANT <u>MR. RAYMOND HOSTETTER</u> | | Address <u>3505 54th AVE. CHEVERLY, MD</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cay the lung</u> DUE TO <u>metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>metastasis</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>12</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8-22-68</u> , 19 <u>68</u> , to <u>8-24</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>8-24</u> , 19 <u>68</u> , and that death occurred at <u>7:30</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | 22b. DATE'S GNED <u>8-24-68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. Lilly</u> | | 22d. ADDRESS <u>Prince Georges Suburb. Cheverly Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Aug 29, 1968</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>BRES Church Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>RT. 2. LEXINGTON, VIRGINIA</u> |
| 24. FUNERAL DIRECTOR <u>W. W. Chamberlain</u> | | 25a. REC'D BY REGISTRAR <u>1400 Chapin St NW</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | DATE <u>SEP 3 1968</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11957

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11965

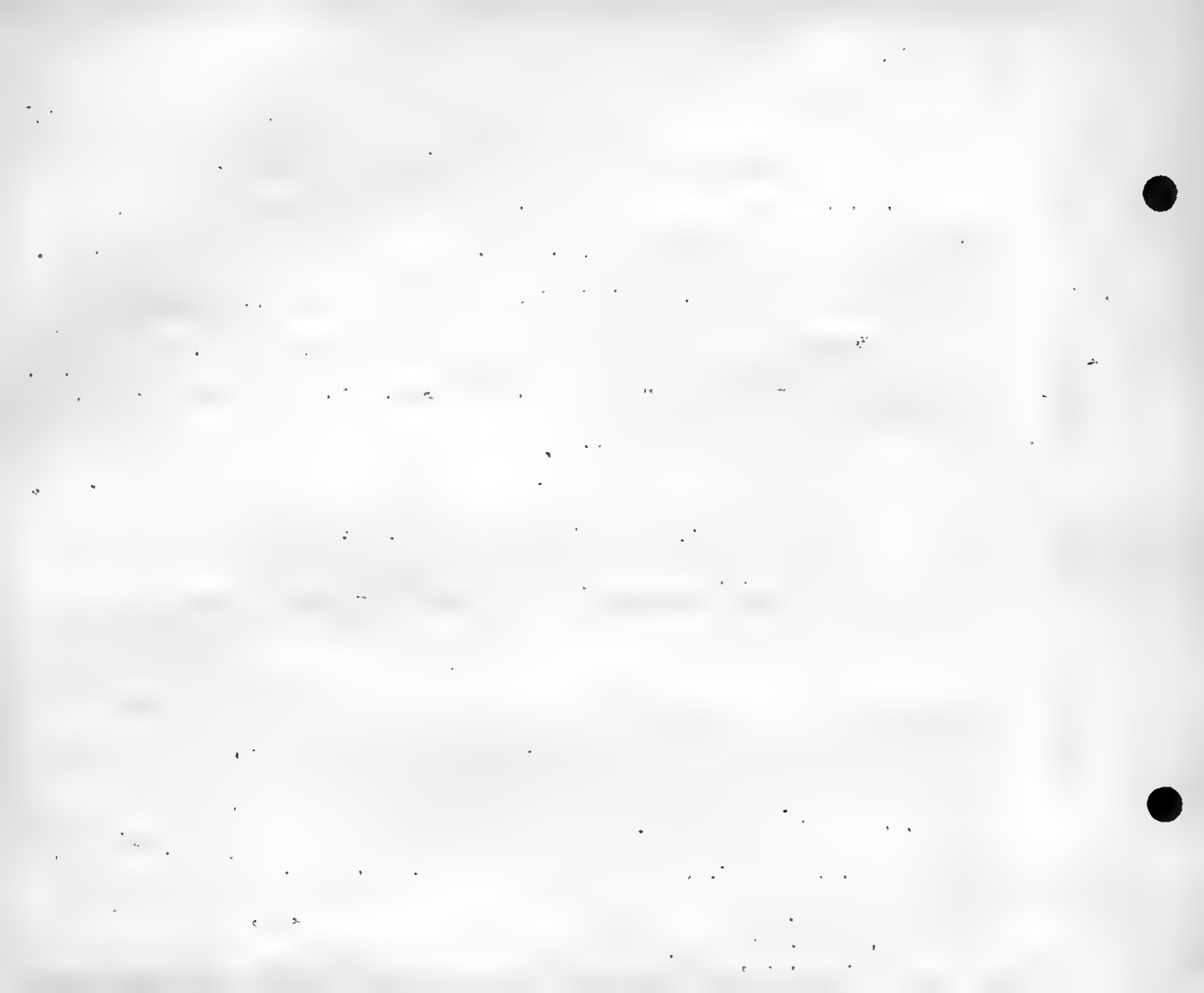
| | | | | | |
|--|------------------------|---|--|---|---|
| 1. DECEASED-NAME (Type or print) First Middle Last William E. Howard | | | 2a. DATE OF DEATH Month Day Year Aug. 29 1968 | | 2b. HOUR M |
| 3 SEX male | 4 RACE cauc. | 5. DATE OF BIRTH June 15, 1919 | | 6 AGE (In years last birthday) 49 YRS | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md |
| 10. CITY OR TOWN OF DEATH Bowie | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt 1 Box 16 | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) carpenter | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | 13b. COUNTY Anne Arundel | 13c CITY OR TOWN Gambrills | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e STREET AND NUMBER Holliday Park |
| 14 FATHER'S NAME First Middle Last Malcolm R. Howard | | 15 MOTHER'S MAIDEN NAME First Middle Last Maude Chandler | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16b SOCIAL SECURITY NO. (If yes give war or dates of service) WW II | 17 INFORMANT Rt 1 Box 16 Mrs. Vanie G. Howard - Bowie, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) General Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Lung DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 weeks | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. | | 21f LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7/3/68 to 8/28/68 , that (I) (we) last saw the deceased alive on 8/28/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Felix J. ... | | 22c. DATE SIGNED 8/30/68 | | 22d. PHYSICIAN'S NAME (Type) Felix J. ... | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug. 31, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Church of God Cemetery | |
| 23d. LOCATION (City or Town) (County) (State) Gambrills A.A. Md. | | 24. FUNERAL DIRECTOR Hopping Funeral Home - Annapolis, Md. | | 25a. REC'D BY REGISTRAR DATE SEP 3 1968 | |
| 25b. REGISTRAR'S SIGNATURE Charles J. ... | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 ☒ be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

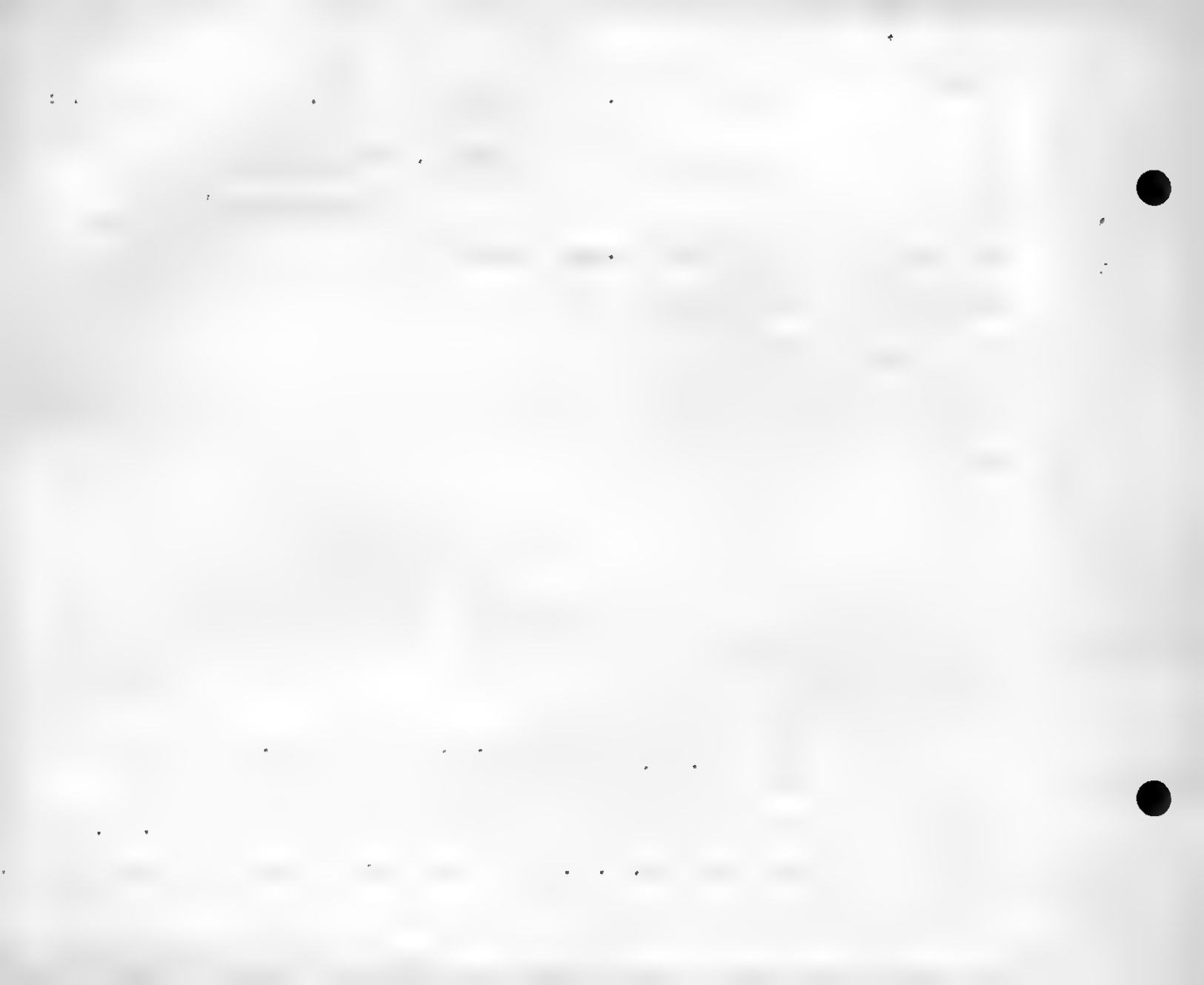
| Item 13 Film 404 9-11-68 MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 11959 CERTIFICATE OF DEATH 11367 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Lida Hutchinson | | | | | | 2a. DATE OF DEATH Month Day Year August 13 1968 | | | 2b. HOUR A M 3:35 M | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH 4/27/73 | | 6 AGE (n years last birthday) 95 YRS. | | IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) Wash., D.C. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md | | | | | |
| 10 CITY OR TOWN OF DEATH Riverdale | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Examiner | | | 12b. KIND OF BUSINESS OR INDUSTRY US Gov't. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE DC | | | 13b. COUNTY Pr. George's | | | 13c. CITY OR TOWN Washington | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last James Fulllove | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Frances A. Stowe | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) NO | | | 16b. SOCIAL SECURITY NO 577-10-4442 | | | 17. INFORMANT Address E. Leland Mem. Hosp. 4408 Queensbury Rd. Riverdale, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Generalized | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 10 minutes 50 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Anemia & Uremia | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not-white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 31 May 1963 , to 13 August 1968 , that (I) (we) last saw the deceased alive on 13 August 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Walter W. Gibson M.D. DEGREE | | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED 13 August 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) W.W. Gibson, M.D. | | | | | | 22e. ADDRESS 4300 St. Barnabas Road, Marlow Heights, Maryland 20031 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 8-15-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Suitland, Maryland | | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Rd. SE, Suitland, Maryland | | | | | | 25a. REC'D BY REGISTRAR DATE AUG 20 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



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| 11960 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 21968 | |
|---|--|--------|--|---|--|--|--|--|--|---|--|--|--|----------------------|--|-----------------------|--|--|--|---------------------------|--|
| 1 DECEASED NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | |
| Gladys A. Jackson | | | | | | | | | | Aug. Month 29, Day 1968 | | | | | | | | | | 11:45 PM | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS. HOURS | | IF UNDER 1 YEAR DAYS | | IF UNDER 24 HRS. MIN. | | | | | |
| Female | | Negro | | June 1, 1907 | | | | 61 YRS. | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | Md | | | | | |
| B. Geo. Co. Md | | | | U.S.A. | | | | | | | | Prince George's | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | |
| Cheverly | | | | Prince Geo. Gen'l Hospital | | | | | | | | | | | | | | | | | |
| 13a USUAL RES DENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b COUNTY | | | | 13c CITY OR TOWN | | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e STREET AND NUMBER | | | | | |
| Maryland | | | | Prince George's | | | | Clinton | | | | | | | | | | | | | |
| 14 FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | |
| Unknown | | | | Unknown | | | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | 16b SOCIAL SECURITY NO | | | | 17. INFORMANT | | | | Address | | | | | | | | | |
| | | | | | | | | Thomasine Young | | | | Deyson Rd. Brandywine, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1830 Collypus + Cardiac arrest | | | | | | | | | | 2-5 months | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) 1830 severe cachectia | | | | | | | | | | 2 months | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Advanced carcinoma of ovary | | | | | | | | | | 6 months | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | |
| 1750 Syphilis & old age | | | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | |
| 14 August '68 | | | | Removal of (inoperable) tumor | | | | | | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from Aug. 5, 1968, to Aug. 29, 1968, that (X) (we) last saw the deceased alive on Aug. 29, 1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE | | | | | | | | | | 22c DATE SIGNED | | | | | | | | | | | |
| Mohammad Bararsani | | | | | | | | | | Aug. 30, 1968 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | |
| Mohammad Bararsani, M. D. | | | | | | | | | | Prince George's General Hospital, Cheverly, | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b DATE | | | | 23c NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION (City or Town) (County) | | | | | | | | | |
| Burial | | | | Sept. 4, 1968 | | | | Union Bethel Ch. Cem. Brandywine P. Geo. Md. | | | | Maryland | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | 25a REC'D BY REGISTRAR | | | | | | | | | | 25b REGISTRAR'S SIGNATURE | |
| Hester Wilson | | | | | | | | | | SEP 6 1968 | | | | | | | | | | Charles Judge | |



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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--------------------------|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | |
| Harry H. Jackson | | | | | | Aug. 19, 1968 | | 10:40 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR MONTHS DAYS | |
| Male | | Caucasian | | March 7, 1895 | | 73 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Md | | U S A | | | | Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 1. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cheverly | | Prince Geo. Gen'l Hospital | | Salesman | | Office supplies | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Prince George's | | Cottage City | | | | 3712 37th Avenue | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | |
| James B Jackson | | | | | | Nettie Knight | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| no | | | | | Matilda M Jackson Cottage City, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION, ACUTE</u> <u>4/10/68</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>2 DAYS</u> <u>2 YEARS</u> | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <u>ix...</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSED DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) person attended the deceased from <u>JAN 1, 1966</u> to <u>AUG 19, 1968</u> , that (I) was <u>did not</u> see the deceased alive on <u>AUG 19, 1968</u> , and that in (my) your <u>my</u> opinion death occurred on the date and hour and from the causes stated above, (I) was <u>did</u> (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Samuel J. N. Sugar</u> MD | | | | | 22c. DATE SIGNED <u>Aug 19, 1968</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) Samuel J. N. Sugar, M. D. | | | | | 22e. ADDRESS 4637 Eastern Ave., Washington, D.C. 20018 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Aug 22, 1968 | | Ft Lincoln Cemetery | | Colmar Manor Pro Geo Md. | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 22 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV. 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (Type or print) Ruth | | First D. | | Middle Johnson | | 2a. DATE OF DEATH 8 Month 20 Day 68 Year | | 2b. HOUR 10 A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 7-5-02 | | 6. AGE (in years last birthday) 66 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) N. Carolina | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md | | | |
| 10. CITY OR TOWN OF DEATH Riverdale | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Eugene Leland Memorial Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Prince George's | | 13c. CITY OR TOWN College Pk. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER +330 Hartwick Rd. Apt. 415 | |
| 14. FATHER'S NAME Alfred H. Daly | | First H. | | Middle Daly | | 15. MOTHER'S MAIDEN NAME Henrietta Peall | | First Peall | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-36-8339 | | 17. INFORMANT Patient and medical records | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmias 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours 3 days | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-17-68 , 19____, to 8-20-68 , 19____, that (I) (we) last saw the deceased alive on 8-20-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE C. J. Houmann | | DEGREE MD | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (Type) C. J. Houmann, M. D. | | 22e. ADDRESS 4404 Queensbury Road, Riverdale, Md. | | | | | | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug 22, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor, Pro Geo Md. | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR AUG 23 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11963

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11971

| | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Anna S Kane | | | 2a. DATE OF DEATH Month August Day 21 Year 1968 | | | 2b. HOUR 9 P. M. | | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH 8/13/1891 | | 6. AGE (In years last birthday) 77 YRS. | | 7. IF UNDER 1 YEAR MONTHS 8 DAYS 8 | | |
| 7a. BIRTHPLACE (State or foreign country) New York City | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md | | | | |
| 10. CITY OR TOWN OF DEATH Hyahtsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hyahtsville Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Gov. worker | | | 12b. KIND OF BUSINESS OR INDUSTRY Business | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Prince George's | | 13c. CITY OR TOWN Hyahtsville | | 13d. INSIDE CITY, IN 157 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 6500 20th Ave. | |
| 14. FATHER'S NAME First Frederick Middle Steinzel Last Barbara | | | 15. MOTHER'S MAIDEN NAME First Barbara Middle Quinn Last Quinn | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO. 155-14-1872 | | 17. INFORMANT Name Robert F. Kane Address 6500 20th Ave. Hyahtsville Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Stroke, decubitus ulcers. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369 (b) Generalized Arteriosclerosis. DUE TO, OR AS A CONSEQUENCE OF (c) Age. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH > 2 weeks. Years. | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 14x | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to Aug. 21 , 19 68 , that (I) (we) last saw the deceased alive on Aug. 21 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Hugo G. Graziani | | | | 22c. DATE SIGNED 8/21/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) HUGO G. GRAZIANI | | | | 22e. ADDRESS 10101 Georgia Ave., S. S., Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 23b. DATE 8/24/1968 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Suitland, Maryland | | | |
| 24. FUNERAL DIRECTOR alley's Funeral Home Mt. Rainier, Md. | | | | 25a. RECD BY REGISTRAR DATE AUG 26 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 11964 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 11972 | | | | | | | | | |
|---|--|--|-----------------------------|--|---|---|--|--|-----------------------------------|---|--|----------------------------|--|--|---|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|
| 1 DECEASED NAME (Type or print) First Middle Last | | | | | | | | | | 2a DATE OF DEATH Month Day Year | | | | | | | | | | 2b HOUR | | | | | | | | | |
| ADAM KAUFHANN | | | | | | | | | | AUG. 7 1968 | | | | | | | | | | PM | | | | | | | | | |
| 3 SEX | | | 4 RACE | | | 5 DATE OF BIRTH | | | 6 AGE (In years last birthday) | | | 7 UNDER 1 YEAR MONTHS DAYS | | | 8 UNDER 24 HRS HOURS MIN | | | | | | | | | | | | | | |
| MALE | | | White | | | 2-3-1878 | | | 90 YRS | | | | | | | | | | | | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | 7b CITIZEN OF WHAT COUNTRY? | | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | |
| Germany | | | U.S.A. | | | | | | Prince George's County Clinton Md | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | |
| Clinton, Maryland | | | | | Ave View Gardens | | | | | Bricklayer | | | | | | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | 13b COUNTY | | | | | 13c CITY OR TOWN | | | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e STREET AND NUMBER | | | | | | | | | |
| Maryland | | | | | Prince Georges | | | | | Gxon Hill | | | | | YES | | | | | 434 Kennebec St. | | | | | | | | | |
| 14 FATHER'S NAME First Middle Last | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| UNKNOWN | | | | | UNKNOWN | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | | 16b SOCIAL SECURITY NO | | | | | 17 INFORMANT Address | | | | | | | | | | | | | | | | | | | |
| No | | | | | 147-01-2407A | | | | | Eva Tomsant 134-Rolph Dr SE | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Respiratory Arrest | | | | | | | | | | 10 MIN. | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Acute congestive Heart Failure | | | | | | | | | | 30 MIN. | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) ASCVD with atrial Fibrillation | | | | | | | | | | 7 MOS. | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Benign Prostatic Hypertrophy with uremia | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? None | | | | | | | | | | | | | | |
| None | | | | | None | | | | | None | | | | | None | | | | | | | | | | | | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If neither, note medical examiner) | | | | | 21b TIME OF INJURY HOUR AM Month Day Year | | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | |
| None | | | | | None | | | | | None | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED Where <input type="checkbox"/> Not <input checked="" type="checkbox"/> at work | | | | | 21e PLACE OF INJURY (At home farm street, factory, office, building etc) | | | | | 21f LOCATION Street or RFD No City or Town County State | | | | | | | | | | | | | | | | | | | |
| None | | | | | None | | | | | None | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from Jan 8, 1968, to present, that (we) last saw the deceased alive on 8/1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b SIGNATURE Arthur Shaver, M.D. | | | | | | | | | | 22c. DATE SIGNED 8/1/68 | | | | | | | | | | | | | | | | | | | |
| 22d PHYSICIAN'S NAME (Type) ARTHUR SHAVER STR. MD | | | | | | | | | | 22e ADDRESS 8808 BRANCH AVE. - CLINTON, MD | | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | | | 23b DATE | | | | | 23c NAME OF CEMETERY OR CREMATORY | | | | | 23d LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | |
| Aug. 2-1968 | | | | | Cedar Hill Cemetery | | | | | Clinton Maryland | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Simmons Bros | | | | | | | | | | 25a REC'D BY REGISTRAR | | | | | | | | | | 25b REGISTRAR'S SIGNATURE | | | | | | | | | |
| Simmons Bros 1661 Good Hope Rd | | | | | | | | | | AUG 5 1968 | | | | | | | | | | J Charles Judge | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 48 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 11965 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 11973 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | | | | | | | | | | | | | First Middle Last | | | | | | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Paul H. Kea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | August 19, 1968 | | | | | | | | | | | | | | | 12 Noon | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 SEX | | | | | | | | | | | | | | | 4. RACE | | | | | | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | | | | | | IF UNDER 1 YEAR MONTHS | | | | | | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | | | | | | |
| Male | | | | | | | | | | | | | | | Caucasian | | | | | | | | | | | | | | | Feb. 23, 1886 | | | | | | | | | | | | | | | 82 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | | | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Va | | | | | | | | | | | | | | | U S A | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Prince George's Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Cheverly | | | | | | | | | | | | | | | Prince Geo. Gen'l Hospital | | | | | | | | | | | | | | | Architect | | | | | | | | | | | | | | | Building | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | | | | | | 13b. COUNTY | | | | | | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | | | | | | Prince George's | | | | | | | | | | | | | | | Hyattsville | | | | | | | | | | | | | | | YES | | | | | | | | | | | | | | | 4004 Claggett Road | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | | | | | | First Middle Last | | | | | | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| William P. Kea | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Rebecca P Thompson | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | | | | | | | | | | | | (If yes give war or dates of service) | | | | | | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | | | | | | 17. INFORMANT | | | | | | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| no | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 215 38 3343 | | | | | | | | | | | | | | | Grace F Kea | | | | | | | | | | | | | | | Hyattsville, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | IMMEDIATE CAUSE (a) | | | | | | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4109 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Acute Myocardial Infarction | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 4 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | (b) | | | | | | | | | | | | | | | General atherosclerosis | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Years | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Diabetes mellitus | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | | | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (the doctor) attended the deceased from 8-18, 1968, to 8-19, 1968, that (I) saw the deceased alive on 8-18, 1968, and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | | | | | | DEGREE | | | | | | | | | | | | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | | | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 8-19-68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ronald Fleischer, M. D. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 7411 Riggs Ro., Hyattsville, Md. 20783 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | | | | | | 23b. DATE | | | | | | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Entombment | | | | | | | | | | | | | | | Aug 22, 1968 | | | | | | | | | | | | | | | Ft Lincoln Mausoleum | | | | | | | | | | | | | | | Colmar Manor Pro Geo Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | | | | | | ADDRESS | | | | | | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | F. Gasch's Sons Hyattsville, Md. | | | | | | | | | | | | | | | AUG 22 1968 | | | | | | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

FOR STATE
HEALTH DEPT.

11966

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--------|-------|---|--|---|--|---|------|-------------------------|--|--|--|------------------------|--------------------|---|--|----------------------------------|--|---|--|--|--|----------------------------|--|--|--|
| 1 DECEASED NAME (Type or Print) | | | First | | | Middle | | | Last | | | 2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8-26-68 | | | 2b HOUR 12:05am | | | | | | | | | | | | |
| Harry | | | Klion | | | | | | | | | | | | | | | | | | | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS | | IF UNDER 24 HRS DAYS | | IF UNDER 24 HRS HOURS | | IF UNDER 24 HRS MIN | | 2c DATE PRONOUNCED DEAD Month 8 Day 26 Year 68 19 1:05am M | | | | | | | | | | | |
| Male | | White | | 4-12-1903 | | 65 YRS. | | | | | | | | | | | | | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | | | 7b CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | |
| Russia | | | | U.S.A. | | | | | | | | Prince George's | | | | Md | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | |
| Cheverly | | | | Prince George Hospital | | | | Window Displays | | | | | | | | | | | | | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | | 13b COUNTY | | | | 13c CITY OR TOWN | | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 13e STREET AND NUMBER | | | | | | | | | | | |
| Md. | | | | 5207 Upshur St. P.G. | | | | Bladensburg | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 5207 Upshur St., | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | First | | | | | | Middle | | | | | | Last | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | (If yes give war or dates of service) | | | | | | 16b SOCIAL SECURITY NO | | | | | | 17. INFORMANT | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | Mrs. Lois Klion, 5207 Upshur St. | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | Bladensburg, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Heart failure | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| over 15 yrs. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (b) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes mellitus - over 15 yrs. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20 AUTOPSY? | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No | | | | City or Town | | | | County | | | | State | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | John Kehoe MD | | | | Riverdale, Md. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | ASS STANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b DATE SIGNED 8-26-68 | | | |
| EXAMINER'S NAME (Type) | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) | | | | 23b DATE | | | | 23c NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION (City or Town) | | | | (County) | | | | (State) | | | | | | | |
| Burial | | | | 8/27/68 | | | | King David Mem. Garden | | | | Falls Church, Va. | | | | | | | | | | | | | | | |
| 24 FUNERAL DIRECTOR | | | | 3501 14th St. | | | | 25a REC'D BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | |
| Bernard Danzansky & Sons | | | | Washington, D.C. | | | | DATE AUG 29 1968 | | | | J. Charles Young | | | | | | | | | | | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11967

11975

| | | | | | | | |
|--|--|---|---|---|----------------------|---|--|
| 1. DECEASED NAME (Type or print) First Middle Last DORA MAY YOUNG | | | 2a. DATE OF DEATH Month Day Year August 20 1968 | | 2b. HOUR 11:05 AM | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH June 27, 1905 | | 6. AGE (In years last birthday) YRS MONTHS DAYS HOURS MIN 62 00 00 00 | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md. | |
| 10. CITY OR TOWN OF DEATH Millersville, Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) St. Joseph's Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Prince George | | 13c. CITY OR TOWN St. Charles | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 2602 Fairlawn St SE | | 14. FATHER'S NAME First Middle Last John W. Wright | | 15. MOTHER'S MAIDEN NAME First Middle Last Ella A. Wright | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. 000-00-0000 | | 17. INFORMANT Eugene L. Kunko | | Address 215-1st St SE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4/12/68</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Cardio Vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cancer (Carcinoma) breast</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, not by medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 21, 1967</u> to <u>Aug 22, 1968</u> , that (I) (we) lost saw the deceased alive on <u>July 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Dr. Eugene Kunko</u> MD | | | | 22c. DATE SIGNED <u>Aug 22nd 1968</u> | | 22d. ADDRESS <u>Dr SE Forest Hgts, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <u>Aug 26-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Shannon Bros</u> ADDRESS <u>Wash DC</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 26 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

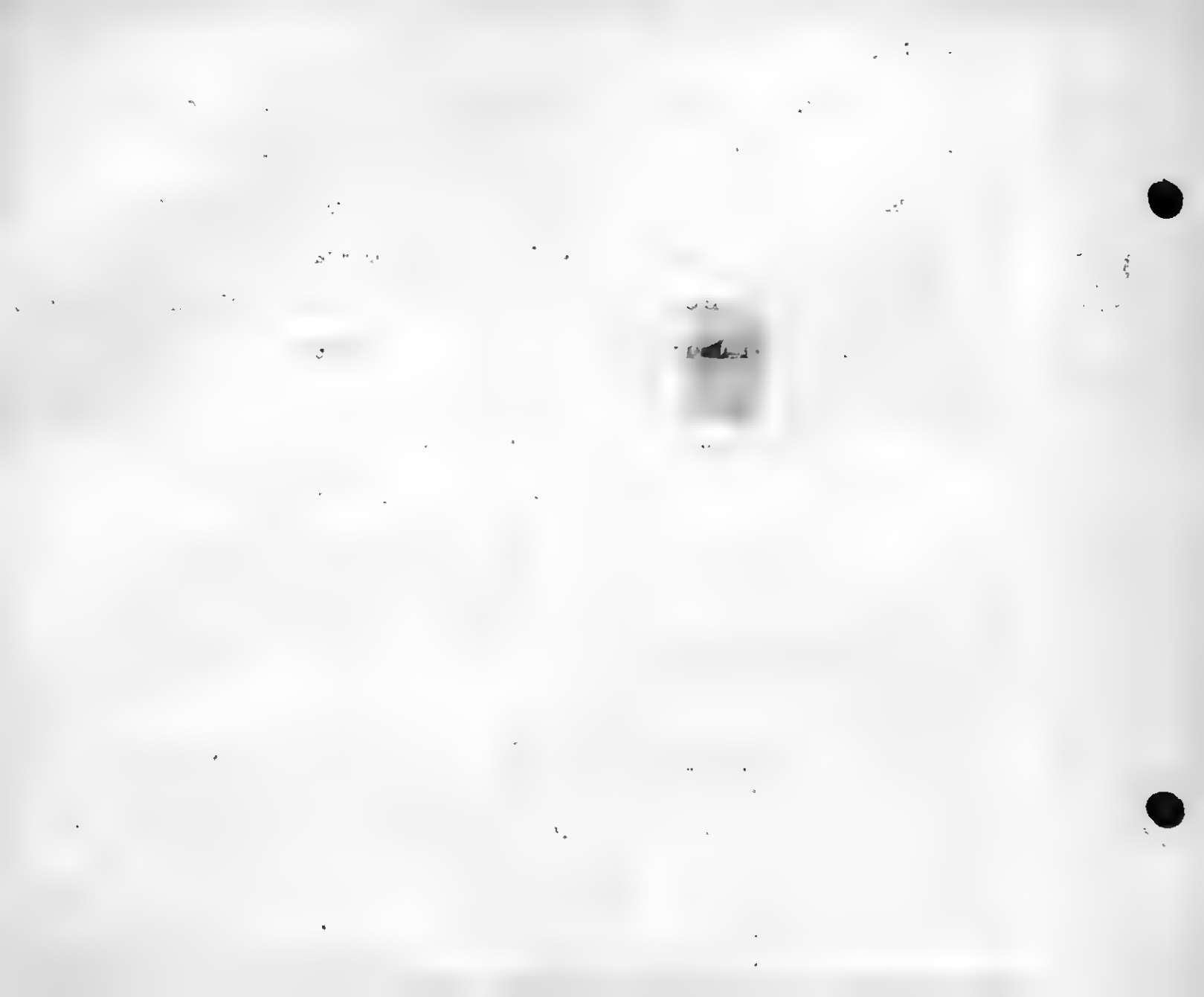
11968

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11976

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Ella M LaBrosse | | | 2a. DATE OF DEATH Month Day Year 8 29 68 | | | 2b. HOUR 10:00 | | | |
| 3. SEX female | | 4. RACE White | | 5. DATE OF BIRTH 6/3/01 | | 6. AGE (In years last birthday) 67 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH Riverdale, | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Prince George | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER 3809 Oglethorpe Street | |
| 14. FATHER'S NAME First Middle Last William Dulaney | | | 15. MOTHER'S MAIDEN NAME First Middle Last Augusta Scott | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | | 16b. SOCIAL SECURITY NO (If yes give year or dates of service) | | 17. INFORMANT Address Hospital record Riverdale, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic Carcinoma - gastro 114X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of breast DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 170X | | | | | | | | | |
| 19a. DATE OF OPERATION 4-4-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of breast | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-9 , 19 68 , to 8-29 , 19 68 , that (I) (we) last saw the deceased alive on 8-28 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE D. R. Purdie M.D. DEGREE | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED Aug 29, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) D R Purdie | | | | 22e. ADDRESS Hospital Riverdale, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug 31, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR SEP 3 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Five Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11969

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--------|-----------------------------|---|--|-----------------------------------|---|--|---------------------------|---|---|---------------------|
| 1 DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | | 2b HOUR | | |
| Audrey Joan Lampkin | | | | | | Month Day Year | | | 8-29-68 19 8:43pm | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | 2c DATE PRONOUNCED DEAD | | | 2d HOUR |
| Female | White | 1-6-1932 | 36 YRS | | | | | Month Day Year | | | 8 29 68 19 9:42pm M |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Mass. | | U.S.A. | | | | Prince George's Md | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince George Hospital | | | Housewife | | | own home | | |
| 13a USUAL RESIDENCE (Where deceased lived 12 months before death) | | | 13b CITY OR TOWN | | | 13c INSIDE CITY LIMITS? | | | 13e STREET AND NUMBER | | |
| Maryland | | | Brandywine | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 12404 Morgan Drive | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Step-father XXXXX Edmund | | | Dorothy (Unknown) | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| No | | | 004-28-4159 | | | Charles G. Lampkin | | | 12404 Morgan Dr. Brandywine, Md. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hemorrhage and shock | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Rupture of thoracic aorta | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | |
| | | | | | | | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 2. a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| | | | 8:40pm 8-29- 19 68 | | | Pedestrian struck by pick-up truck. | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | U.S.Rt. 301, North of Surrats Rd., Cheltenham, Prince George Co., Md. | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 8-30-68 | | |
| John Kehoe MD | | | Riverdale, Md. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | Sept. 3, 1968 | | St. Lincoln Cemetery | | Bladensburg Pr. Geo. Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a REC'D BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| M. Andrew Dwyall Warner E. Humphrey, Inc. 8434 Ga. Ave. Sil. Spr. Md. | | | | | | SEP 5 1968 | | J. Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

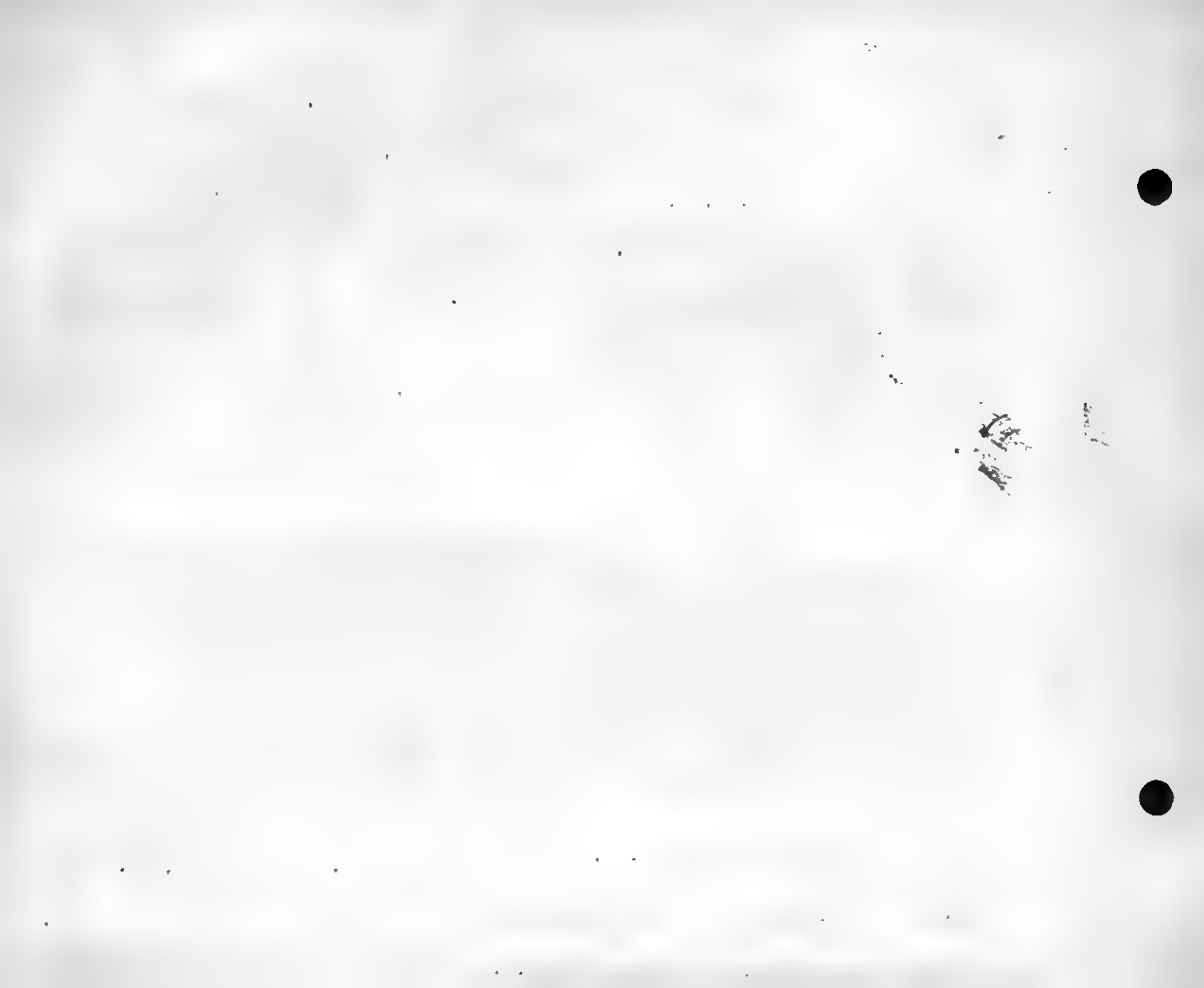
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers (pages 1 and 2) and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11970

11978

| | | | | | | | | | | | |
|---|--|--|--|---|------|--|------------------------------------|--|--|---|--------------------------------|
| 1 DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR P | | |
| Louis Lantos | | | | | | Aug. 19, 1968 | | | 12:45 | | |
| SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. |
| Male | | Caucasian | | January 27, 1892 | | | 76 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | Md | |
| Hungary | | U. S. A. | | Prince George's | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince Geo. Gen'l Hospital | | | Self Employed | | | Restaurant | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admiss on) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| Maryland | | | Prince George's | | | Silver Sprg. | | | 8500 New Hampshire Avenue | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| Carl Lantos | | | Bertha | | | | | | ? | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | Address | | |
| Yes | | | 185-03-2085 | | | Helen Lantos, | | | Same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>General and arteriosclerotic Cardio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Given</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Asabete mellitus, Prostatic hyperplasia</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) this hospital attended the deceased from <u>19-64</u> , to <u>8-19-68</u> , that (I) last saw the deceased alive on <u>8-18-19-68</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) will (d) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Ronald Fleischer</u> | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED <u>8-19-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) Ronald Fleischer, M.D. | | | | | | 22a. ADDRESS 7411 Riggs Rd., Hyattsville, Md. 20783 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 8-20-1968 | | National Memorial Park | | | | Falls Church | | Va. | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Goldberg Funeral Home, 4217 9th Street N.W. | | | | | | | | AUG 22 1968 | | <u>Charles J. Jager</u> | |



4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 11972 Items 7a & 7b 11-16-68 11-16-68 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Florence M. Leonard | | | | | | August 21, 1968 | | 6:25 P | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | Caucasian | | May 28, 1887 | | 81 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | USA | | | | Prince George's | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | | Prince Geo. Gen'l Hospital | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY, APTS? | |
| Maryland | | | Prince George's | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET AND NUMBER | | | |
| BENJAMIN F. ARRINGTON | | | LOUISE CONWELL | | | 294 Forest Lane, Rt. #1 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | Address | |
| | | | | | | Mary E Phipps | | 294 Forest Lane | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> | | | | | | | | 1 day | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>337 X</u> | | | | | | | | | |
| (b) <u>Cerebral arteriosclerosis</u> | | | | | | | | 10 years | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| <u>Perforated acute diverticulum of sigmoid & anastomosis</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 8-9-1968 | | See 18, sent 2. | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | |
| 22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1961</u> to <u>8-21</u> , 19 <u>68</u> , that (I) <u>(yes)</u> last saw the deceased alive on <u>8-21</u> , 19 <u>68</u> , and that in (my) <u>(best)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(yes)</u> (did) <u>(not)</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| <u>Hans Wodak M.D.</u> | | <u>8-22-1968</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Hans Wodak, M. D. | | Prof. Bldg. Centerway, Greenbelt, Maryland | | | | | | | |
| 23a. BURIAL <u>CREMATION</u> | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| <u>Removal (Specify)</u> | | <u>8-24-68</u> | | <u>Woodlawn Cem</u> | | <u>Woodlawn B2 H Co Md</u> | | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| <u>Burgess Funeral Home B2 H Co Md</u> | | DATE <u>AUG 27 1968</u> | | <u>Charles Judge</u> | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

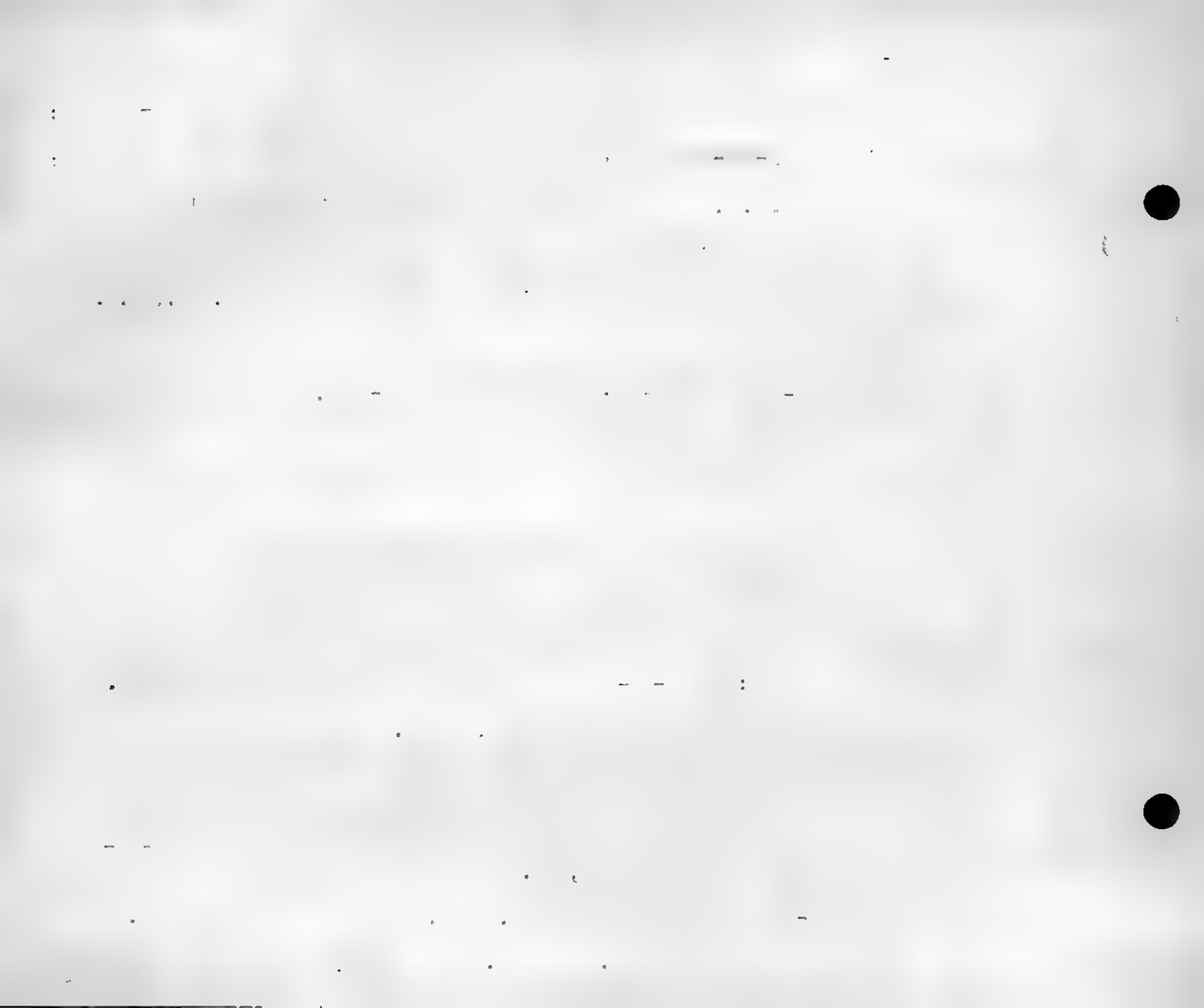
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11972

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11980

| | | | | | | | | | | | |
|---|--------------------|---|---|--|------------------------------|---|--|---|---|--|--|
| 1 DECEASED NAME (Type or Print) (George) Kung Son | | | First Middle Last | | | 2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 8-11-68 19 | | | 2b HOUR 11:00am | | |
| 3 SEX Male | 4 RACE Oriental | 5 DATE OF BIRTH 6-10-1906 | 6 AGE (In years last birthday) 62 YRS | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN | 2c DATE PRONOUNCED DEAD Month 8 Day 11 Year 68 19 | | | 2d HOUR 11:10am | | |
| 7a BIRTHPLACE (State or foreign country) China | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Prince George's Md | | | | | |
| 10 CITY OR TOWN OF DEATH Cheverly | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laundry Operator | | | 12b KIND OF BUSINESS OR INDUSTRY Laundry | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution, on residence before admission) STATE District of Columbia | | 13b CITY OR TOWN Washington | | 13c INSIDE CITY (Lat 152) YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d STREET AND NUMBER 3420 11th. St., N.W. | | | | | |
| 14 FATHER'S NAME Unknown | | | | 15 MOTHER'S MAIDEN NAME Unknown | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b SOCIAL SECURITY NO. (If yes give year or dates of service) - | | 17 INFORMANT Linda Yun-dau. Same as #13 | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of heart</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION 7 | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. 10:50am 8-11- 19 68 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Driver of car involved in collision. | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Baltimore Washington Parkway, at Rt. 193 | | 21f LOCATION Street or R F D No. City or Town County State | | | | | | | |
| 22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD | | 22b DATE SIGNED 8-12-68 | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b DATE 8-18-1968 | | 23c NAME OF CEMETERY OR CREMATORY George Wash. Cem. | | 23d LOCATION (City or Town) (County) (State) Hyattsville, Md. | | | | | |
| 24 FUNERAL DIRECTOR Lee Funeral Home 300 4th St. NE Wash., DC | | | | 25a REC'D BY REG-STRAR DATE AUG 19 1968 | | 25b REGISTRAR'S SIGNATURE J Charles Judge | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11973

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

81

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|----------|-------------------|------------------------------|--|--|--|--|-------------------|-----------------|--|--|--|--|--|----------------------------|--|-----------------------------------|--|--|--|--|--|
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | | 2b. HOUR | | | | | | | | | | | |
| Po Lin Lew | | | | | | 8-11-68 | | | 19 | | | 11:55am | | | | | | | | | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | | | | | | | | |
| Female | | Oriental | | 3-23-1924 | | 44 YRS | | MONTHS DAYS | | HOURS MIN | | 8 Month 11 Day 68 Year | | 11:55am | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | | | | | | | | | | | |
| China | | | | U.S.A. | | | | | | | | Prince George's Md | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Cheverly | | | | | | Prince George Gen. Hospital | | | | | | Laundry Operator | | | | | | Laundry | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | | | | | 13b. CITY OR TOWN | | | | | | 13c. INSIDE CITY LIMITS? | | | | | | 13d. STREET AND NUMBER | | | | | |
| District of Columbia | | | | | | Washington | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | 3420 11 th. St., N.W. | | | | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | | | | | | | | | | | | | |
| Tom | | | Yuen | | | June | | | Y. | | | Yuen | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT | | | | | | ADDRESS | | | | | |
| No | | | | | | 579-54-8486 | | | | | | Linda Yun-dau. | | | | | | Same as # 13 | | | | | |
| MEDICAL CERTIFICATION 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral hemothorax</u> <u>121</u> DUE TO, OR AS A CONSEQUENCE OF <u>Multiple rib fractures</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | | | | | | | | | | | | | | | | | |
| <u>8164</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | | | | | | | | | |
| | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | | | 21b. TIME OF INJURY Month, Day, Year | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 10:50am 8-11-19 68 | | | | | | Passenger of car involved in collision. | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | |
| Baltimore | | | | | | Washington Parkway at Rt. 193 | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 22b. DATE SIGNED | | | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | 8-12-68 | | | | | | | | | | | |
| John Kenoe MD | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | ADDRESS (Street, city, town, or country) | | | | | | | | | | | |
| Riverdale, Md. | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL CREMATION REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | |
| Burial | | | | 8-18-1968 | | | | George Wash. Cem. | | | | Hyattsville, Md. | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Lee Funeral Home 300 4th St. NE Wash., DC | | | | | | | | | | | | AUG 19 1968 | | | | Charles Judge | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------|---|------------------|------------------------------------|--|--|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| Item 6 Film G404-1-1000-1000 | | | | | | | | | | | |
| 11974 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| First Middle Last Lou Edna Lewis | | | | | | Month Day Year 8 23 68 | | | 4:45 PM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | 7. UNDER 1 YEAR | | 7. UNDER 24 MRS. | |
| F | | N | | 9-12-89 | | 78 1/4 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Virginia | | | U.S.-A | | | | | | Pr. George Md | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, except retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Clinton | | | Pineview Gardens | | | House wife | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| WASH DC | | | | | | | | | | 2213 Rand Pl N.E. | |
| 14. FATHER'S NAME | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| First Middle Last Charles Carrington | | | | | | First Middle Last Diolet Coles | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| NO | | | | | | | | Daughter 2213 Rand Pl N.E. Wash DC | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> | | | | | | | | | | 10 MIN. | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular accident</u> | | | | | | | | | | 4 1/2 days | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Cardiovascular</u> | | | | | | | | | | 15+ years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | | | | | | | | |
| None | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| None | | | None | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, nothing need be answered) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| None | | | None | | | None | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | | 21f. LOCATION | | | | | |
| None | | | None | | | None | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 7/15/68 to present, that (I) last saw the deceased alive on 8/20/68 and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | 22c. ATTENDING PHYS | | 22d. MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22e. DATE SIGNED | |
| Arthur Snaver Jr. MD | | | | | | | | | | 8/23/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| ARTHUR SNAVER JR. MD | | | | | | 8808 BRANCH AVE CLINTON, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCAL (City or Town) (County) (State) | | | |
| Burial | | | 8-25-68 | | TRIUMPH BAPTIST CEM. | | | FARMVILLE, VA. | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| George R. Snowdon Reville | | | | | | DATE AUG 28 1968 | | John J. J. J. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and attach them to the certificate. The certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 11975 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 21983 | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) First Middle Last FRED B. LIN FOOT | | | | | | | | | | 2a. DATE OF DEATH 8 Month 16 Day 1968 Year 26 HOUR 27 M | | | | | | | | | | | | | | | | | | | |
| 3. SEX M | | | 4 RACE W | | | 5. DATE OF BIRTH 1/30/1877 | | | 6. AGE (In years last birthday) 91 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | | | | | | |
| 7a BIRTHPLACE (State or foreign country) Kentucky | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH PR. Geo. Co. | | | Md. | | | | | | | | | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH Clinton, Md. | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine View Gardens Health Center | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN Wash. D.C. | | | 13d. NO. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 1601 Argonne Place N.W. | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO 579-60-2575T | | | | | 17 INFORMANT J. Pritchard | | | | | Address 286 - Fort Baker Dr. S.E. Wash. D.C. 20020 | | | | | | | | | | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4127 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE PULMONARY EMBOLUS DUE TO, OR AS A CONSEQUENCE OF (c) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 14 HRS. | | | | | | | | | | 14 HRS. | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE | | | | | | | | | | DISEASE | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. <input checked="" type="checkbox"/> (If either, note medical examination) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED (At home, farm, street, factory, etc.) | | | 21e. PLACE OF INJURY (Office, building, etc.) | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 8/13, 1968 to PRESENT, that (I) () last saw the deceased alive on 8/15, 1968 and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE Arthur Shaver, M.D. | | | | | | | | | | 22c. DATE SIGNED 8/16/68 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR. M.D. | | | | | | | | | | 22e. ADDRESS 8808 BRANCH AVE. - CLINTON, MD. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE 8-19-1968 | | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | | | 23d. LOCATION (City or Town) (County) (State) Suitland Pk. Md | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR M. M. 131-11th St. S.E. D.C. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE AUG 19 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | | | | | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11976

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1968

| | | | | | | | | | | | | | |
|--|---------|------------------------------|--|---|------|--|--|--|--|-----------------------|--|---------|---------|
| 1 DECEASED NAME (Type or Print) | | | First | Middle | Last | 2a DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> | | | Month | Day | Year | 2b HOUR | |
| Alice | | | B | | Lion | 8-25-68 | | | 19 | 4 | 44 | PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS. HOURS MIN | | 2c DATE PRONOUNCED DEAD | | Month | Day | Year | 2d HOUR |
| Female | White | 1-10-1896 | 72 | YRS | | | | 8 | | 25 | 68 | 19 | 4:44 PM |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | |
| WASHINGTON, DC | | U.S. | | | | Prince George's Md | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| Cheverly | | | Prince George Hospital | | | HOUSEWIFE | | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e STREET AND NUMBER | | | |
| Maryland | | | Prince George's | | | Landover | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 6507 Landover Road | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15 MOTHER'S MAIDEN NAME | | | First | Middle | Last | | |
| WILLIAM | | | HARRISON | | | ELIZABETH | | | MADDON | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT | | | ADDRESS | | | | |
| No | | | UNKNOWN | | | ALVIN E. LION | | | 3512 Burruss Ave Fairfax, Va. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. over 1 yr. | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4</u> | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No | | | City or Town | | County State | | |
| | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | | |
| EXAMINER'S NAME (Type) | | | John Kehoe MD Riverdale, Md. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 8-26-68 | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | | |
| | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | | AUG-28, 1968 | | | GEORGE WASHINGTON MEM PK | | | HYATTSVILLE, MARYLAND | | | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REG STRAR | | | 25b REGISTRAR'S SIGNATURE | | | | |
| W.W. CHAMBERS CO. RIVERDALE, MD | | | | | | DATE SEP 3 1968 | | | Charles Judge | | | | |

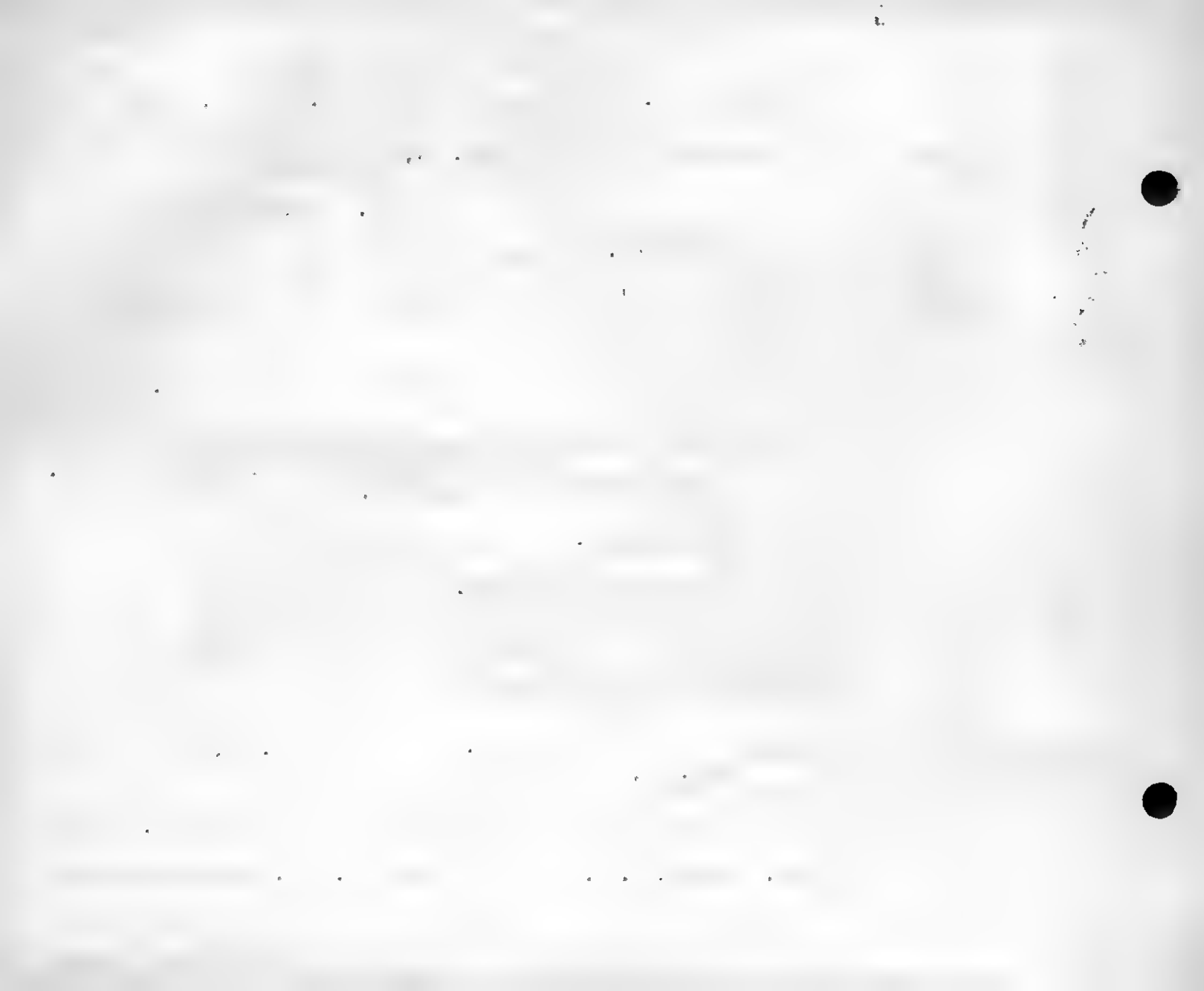


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6/28/68

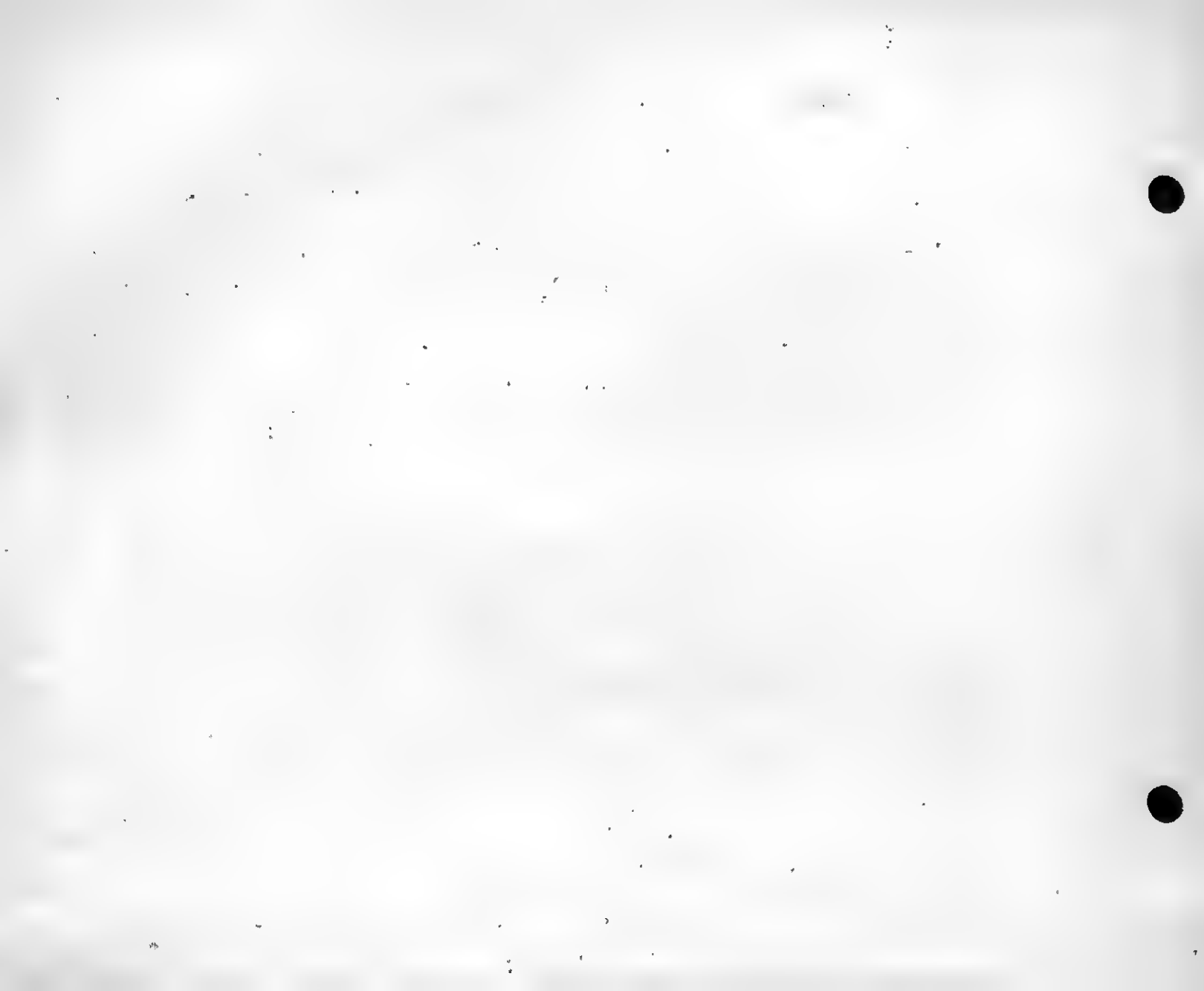
| | | | | | | | | | |
|--|--|--|-------|---|---------|--|--|---|------------------------------|
| 11977 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 1968 | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month 13, Day 1968 Year | | 2b. HOUR P 12:30 M | |
| Luella | | | L. | | Logsdon | | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH Feb. 24, 1920 | | 6. AGE (In years last birthday) 48 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Iowa | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Sep. Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo.Gen'l Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Prince George's | | 13c. CITY OR TOWN Landover | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 6513 Landover Road | |
| 14. FATHER'S NAME First ? | | Middle Langman | | Last | | 15. MOTHER'S MAIDEN NAME First ? | | Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) no | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Hugh W Logsdon | | Address Kentland, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) <u>Diffuse abdominal carcinomatosis with fistulus</u> DUE TO, OR AS A CONSEQUENCE OF <u>tract from cancerous colon to abdominal wall.</u> (b) <u>Pulmonary edema and congestion.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiomegaly.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1538</u> <u>Cirrhosis of the liver.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>Sept. 21, 1966</u> to <u>Aug. 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug. 13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (didn't) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Don B. Cameron</u> | | | | 22c. PHYSICIAN'S NAME (Type) Don B. Cameron, M. D. | | 22d. ADDRESS 3503 Perry St., Mt. Rainier, Maryland | | 22e. DATE SIGNED Aug. 13, 1968 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug 16, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR DATE AUG 16 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|---|---|--|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Mabel C. Loveless | | | 2a. DATE OF DEATH Month 8 Day 25 Year 68 | | | 2b. HOUR 7:30 M | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 11/27/03 | | 6. AGE (In years last birthday) 64 YRS | | IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md. | | | | |
| 10. CITY OR TOWN OF DEATH Riverdale | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Prince George's | | 13c. CITY OR TOWN College Park | | 13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 5814 Seminole Street | |
| 14. FATHER'S NAME First Middle Last John R. McDemrott | | | 15. MOTHER'S MAIDEN NAME First Middle Last Rose M Abigail | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | | | 16b. SOCIAL SECURITY NO. 218 30 4310 | | 17. INFORMANT Address James C Loveless College Park, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Decomposition Re Coronary Artery 4104 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Since funeral home removed DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/19/68 to 8/25/68 , that (I) (we) last saw the deceased alive on 8-21-68 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Robert C. Wingfield | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 8/27/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Robert C Wingfield | | | | | 22e. ADDRESS 329 Pro Geo st Laurel, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug 28, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | | | | |
| 24. FUNERAL DIRECTOR F Gasch's Sons Hyattsville, Md. | | | | | 25a. REC'D BY REGISTRAR DATE AUG 29 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--------------------------|--|--|--|--|--------------------------------|--|
| 11979 CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| EDWARD RAYMOND MAHALICK | | | | | | AUG 15 1968 | | 8:22 M | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (In years) | | IF UNDER 1 YEAR | |
| MALE | | CAU | | 18 Dec 1926 | | 42 1/2 YRS. | | MONTHS DAYS HOURS M N. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md | |
| Pa. | | U.S.A. | | | | PRINCE GEORGES' | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| ANDREWS AFB | | MALCOLM GROW USAF HOSP | | RETIRED | | USAF | | | |
| 13a. US JAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD | | PRINCE GEORGES | | SPRINGS | | | | 7915 Carswell Dr. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| JOSEPH MAHALICK | | | Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17 INFORMANT Address | | | |
| | | | 202161320 | | | WIFE MARY A. MAHALICK SAME AS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>with Myocardial infarction</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 420. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| 22a. I certify that (this hospital) attended the deceased from 15 Aug, 1968, to 15 Aug, 1968, that (we) lost the deceased alive on 15 Aug 1968 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S | | | | | |
| | | 15 Aug 68 | | GEORGE E. CIMOCHOWSKI, M.D. | | | | | |
| 22e. ADDRESS | | 22f. ADDRESS | | 22g. ADDRESS | | | | | |
| | | | | MALCOLM GROW USAFH ANDREWS AFBMD | | | | | |
| 23a. BURIAL OR CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | 23e. LOCATION (County) (State) | |
| Burial | | 8-19-68 | | Arlington Nat'l Cem. | | Arlington, Virginia | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wilhelm Funeral Home | | | | DATE | | AUG 27 1968 | | | |
| 4308 Suitland Rd., Suitland, Maryland | | | | | | J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|---|--|------------------|--|---|---|-----------------------|--|---------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| William T. Mahorney | | | | | | Month 8 Day 15 Year 1968 | | 10:20 PM | | | |
| 3 SEX | | 4 RACE | | 5 DATE OF BIRTH | | 6 AGE (In years last birthday) | | 7 IF UNDER 1 YEAR MONTHS DAYS | | | |
| Male | | White | | 8/8/1915 | | 53 YRS. | | | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| D. C. | | U.S.A. | | | | Prince Georges Md. | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Glenn Dale | | | Glenn Dale Hospital | | | unknown - unemployed | | unknown | | | |
| 13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE | | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e STREET AND NUMBER | | |
| Washington, D.C. | | | unk. | | | | No fixed address | | | | |
| 14 FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Bernard | | | | | -- Mahorney | Margaret | | | V. | | Belbin |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | | Address |
| | | | | | | 578-18-3000 | | Decedent | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute and chronic respiratory insufficiency | | | | | | | | | | 2 mos. | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary emphysema and fibrosis | | | | | | | | | | unknown | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary tuberculosis | | | | | | | | | | 3 yr. 3 mo. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | | |
| 21a INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | State |
| | | | | | | | | | | | |
| 22a. I certify that the (this hospital) attended the deceased from 9/13/1967, to 8/15/1968, that the (we) lost saw the deceased alive on 8/15/1968, and that in our (our) opinion death occurred on the date and hour and from the causes stated above. the (we) (did) not view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE | | Moe Weiss | | | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c DATE SIGNED 8/15/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | Moe Weiss, M. D. | | | | 22e. ADDRESS | | Glenn Dale Hospital, Glenn Dale, Maryland | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. ADDRESS | | Bethesda, MD | | | |
| Removal | | 8/27/68 | | ANATOMICAL BOARD | | x | | | | | |
| 24 FUNERAL DIRECTOR | | | | | | 25a REC'D REGISTRAR | | 25b REGISTRAR'S SIGNATURE | | | |
| Carl F. Ruppert | | | | | | AUG 27 1968 | | Judge | | | |

1911

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

11981

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George's b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly c. LENGTH OF STAY IN 1b DOA d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Charles c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Welcome d. STREET ADDRESS None e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Joseph Earl Marbury | | | | 4. DATE OF DEATH Month Day Year August 23 1968 | | | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH July 17, 1896 | |
| 9. AGE (In years last birthday) 72 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. 24 24 68 | | 11. BIRTHPLACE (State or foreign country) Pisgah, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic- retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 13. FATHER'S NAME William Henry Marbury | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes World War II | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Norma Keys(daughter) Address Welcome, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4127 Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerotic Heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH Years | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Cornelius J. Burns, M.D. | | | | 22. DATE SIGNED 24 Aug 68 | | | |
| EXAMINER'S NAME (Type) Cornelius J. Burns, M.D. | | | | 23. NAME OF CEMETERY OR CREMATORY ZION BAPTIST CHURCH Cem | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF AUG 28, 1968 | | 23c. LOCATION (City, town or county) (State) Hill Top Md. | | 23d. ADDRESS (Street, city, town, or county) Cheverly, Maryland | |
| 24. FUNERAL DIRECTOR JOHNSON & JENKINS | | | | 25a. REC'D BY REGISTRAR 4804 GA. Ave N.W. 20011 | | | |
| 25b. REGISTRAR'S SIGNATURE gcharles Judge | | | | DATE AUG 28 1968 | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|-------------------------------|--|
| 11982 CERTIFICATE OF DEATH 11990 | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) First FLORENCE Middle TERESA Last MARCHITELLI | | | | | | 2a. DATE OF DEATH Month AUGUST Day 10 Year 1968 | | | 2b. HOUR 1:15 PM | | |
| 3. SEX FEMALE | | 4. RACE CAU | | 5. DATE OF BIRTH 3 NOVEMBER 1921 | | 6. AGE (In years last birthday) 46 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH PRINCE GEORGES Md. | | | | | |
| 10. CITY OR TOWN OF DEATH ANDREWS AFB | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) MALCOLM GROW USAF HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) NURSE | | | 12b. KIND OF BUSINESS OR INDUSTRY MILITARY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. dence before admission) STATE TACHIKAWA AIR BASE, JAPAN | | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| 14. FATHER'S NAME First ALBERTO Middle (NMN) Last MARCHITELLI | | | | 15. MOTHER'S MAIDEN NAME First SIRAGUZA Middle ANTONINA Last MARCHITELLI | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) Active duty | | | | 16b. SOCIAL SECURITY NO. 360-32-8444 | | 17. INFORMANT Mrs. Antonina Marchitelli, Address Box 202, Avonmore, Pa. 15618 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of rectum</u> 1541 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from <u>8 May, 1968</u> , to <u>Aug 10, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 6, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Burton Sack</u> | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED <u>Aug 10, 1968</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Capt. Burton Sack, USAF, MC | | 22e. ADDRESS MALCOLM GROW USAF HOSPITAL ANDREWS AFB, WASH., D.C. 20331 | | | | | | | | | |
| 23a. BURIAL-CREATION, REMOVAL (Specify) | | 23b. DATE 8-13-68 | | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>W. W. Chambers Co. 517-11th St. S.E.</u> | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 19 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | |
|---|--|--|---|--|--|
| 11983 | | | 1968 | | |
| DECEASED NAME (Type or Print) | | | First Middle Last | | |
| Jesse Willard Marshall | | | 2a DATE KNOWN OF ESTI- DEATH MATED <u>8-15-68</u> | | |
| 3 SEX Male | | | 4 RACE White | | |
| 5 DATE OF BIRTH 3-8-1915 | | | 6 AGE (in years last birthday) 53 YRS. | | |
| 7a BIRTHPLACE (State or foreign country) Va. | | | 7b CITIZEN OF WHAT COUNTRY? USA | | |
| 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Prince George's | | |
| 10 CITY OR TOWN OF DEATH Cheverly | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital | | |
| 12a USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) STATE Maryland | | | 12b KIND OF BUSINESS OR INDUSTRY US Gov't. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if not institution. Residence before admission) STATE Maryland | | | 13b. CITY OR TOWN Prince George's Boulevard Hgts. | | |
| 14. FATHER'S NAME Page Marshall | | | 15 MOTHER'S M.A.DEN NAME Lillie Swin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | 16b SOCIAL SECURITY NO 3-1-4512-45 | | |
| 17 INFORMANT Claudette Jones | | | ADDRESS 6821 Riverdale Rd. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Hypertensive cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | M.D. | | 22b. DATE SIGNED 8-18-68 | |
| John Kehoe MD | | Riverdale, Md. | | ADDRESS (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8-20-68 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm | | ADDRESS 4308 Suitland Rd. S. E. | | 25a. REC'D BY REGISTRAR DATE AUG 27 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Jones | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, forwarding the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|--|--|--|---|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Edith | | | Martus | | | MATED <input checked="" type="checkbox"/> 8-17-68 19 | | 8:40pm | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (in years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Female | White | 7-20-1953 | 15 YRS | | | Month 8 Day 17 Year 68 19 | | 8:40pm | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Washington D C | | USA | | | | Prince George's Md | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Riverdale | | | Leland Memorial Hospital | | | Student | | School | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET AND NUMBER | | |
| Maryland | | | Prince George's | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 3224 Gumwood Road | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| John W Martus | | | Edith M Hessler | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| no | | | none | | | Edith M Martus | | | |
| | | | | | | ADDRESS | | | |
| | | | | | | University Hills, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO, OR AS A CONSEQUENCE OF <u>Trauma - bicycle accident</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 843 X | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) | | | | |
| | | | 8:40pm 8-13-1968 | | control and upset. Passenger on bicycle which went out of | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | 6900 block of Calverton Street, Hyattsville, Md. P.G. Co. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 8-18-68 | |
| John Kehoe MD | | | Riverdale, Md. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | Aug 20, 1968 | | Mt Olivet Cemetery | | Washington D. C. | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REG STRAR | | 25b. REGISTRAR'S SIGNATURE | |
| F. Gasch's Sons Hyattsville, Md. | | | | | | DATE AUG 22 1968 | | J. Charles Judge | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--------|--|---|---|--|--|--|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | |
| Elmours Burl McCray | | | | | | Month Day Year | | 8-11-68 1910:57aM | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | 7 UNDER 24 HRS | 8 MONTHS | 9 DAYS | 10 HOURS | 11 MIN. | 12c. DATE PRONOUNCED DEAD | |
| Male | White | 3-21-1905 | 63 YRS. | | | | | | Month Day Year | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| West Va | | | US A | | | | Prince George's Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Prince George Gen. Hosp. | | | Retired | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | |
| West Virginia | | | Tucker | | Davis | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | P.O. Box 363 | |
| 14 FATHER'S NAME | | | 15 MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| George Mc Cray | | | Julia Garrison | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| no | | | | | Hospital record Cheverly Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure | | | | | | | | | minutes | |
| DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease | | | | | | | | | unknown | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | |
| (b) | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 4200 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | HOUR A.M. P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | | |
| EXAMINER'S NAME (Type) | | | ASS STANT MEDICAL EXAMINER <input type="checkbox"/> | | | 8-12-68 | | | | |
| John Kehoe MD Riverdale, Md | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Removal | | | Aug 12, 1968 | | Thomas Duncan Home | | Thomas Tucker West Va | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| F. Lasche, some Hypothetical, Ind | | | | | DATE AUG 14 1968 | | J. Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11986

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1968

| | | | | |
|--|------------------|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Angela A. Melackrinos | | 2a. DATE OF DEATH Month Day Year August 23 1968 | | 2b. HOUR 9:40P M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH 3/25/02 | | 6. AGE (In years last birthday) 66 YRS. |
| 7a. BIRTHPLACE (State or foreign country) GREECE | | 7b. CITIZEN OF WHAT COUNTRY? U. S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 7c. COUNTY OF DEATH Prince George's Md. | | 9. COUNTY OF DEATH Prince George's | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) H/W |
| 13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Maryland | | 13b. CITY OR TOWN Montgomery | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET AND NUMBER 1208 Ruatan St. |
| 14. FATHER'S NAME First Middle Last HOMER ARAKIOS | | 15. MOTHER'S MAIDEN NAME First Middle Last MARIA | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, (If yes give war or dates of service) NO | | 16b. SOCIAL SECURITY NO 022-24-1838 | | 17. INFORMANT Mrs. ROBERT DOLINGER 5337-85 th Ave. MARYLAND MS. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction | | | | |
| (b) pulmonary emboli | | | | |
| (c) | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | |
| 19a. DATE OF OPERATION 7-2 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. cal examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State |
| 22a. I certify that (A) (this hospital) attended the deceased from August 21, 1968, to August 23, 1968, that (A) (we) last saw the deceased alive on August 23, 1968, and that in (xxx) (our) opinion death occurred on the date and hour and from the cause stated above, (A) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Iradj Sadeghian | | 22c. DATE SIGNED 8/24/68 | | 22d. PHYSICIAN'S NAME (Type) Iradj Sadeghian |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 27 AUG. 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Geo. WASHINGTON CEMETERY |
| 23d. LOCATION (City or Town) HATTSVILLE MD. | | 23e. REC'D BY REGISTRAR AUG 27 1968 | | 23f. REGISTRAR'S SIGNATURE Charles Judge |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1-4-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | |
|--|--------|--|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8 20 19 68 am M | | |
| John | | | Richard | | | Merkle | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (in years last birthday) | 7 UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Month 8 Day 20 Year 19 68 9:30 pm |
| M | W | 26 June 1929 | 39 YRS | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md | | |
| Maryland | | U.S.A. | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Beltsville | | | Home | | | Teacher | | Education |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| Md. | | | Prince George | | | Beltsville | | 13e. STREET AND NUMBER 11336 Evans Trail Apt T-2 |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | |
| Richard Merkel | | | | | | Nora Sullivan | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | |
| Yes | | | 214-26-1117 | | | Richard W. Satabe 618 Brisbane Rd. 21229 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Combined intoxication | | | | | | | | 1 hr. |
| DUE TO, OR AS A CONSEQUENCE OF (b) Alcohol & Barbiturate | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. NOON P.M. 8-20 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) Ingested combination alcohol & barbiturate | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | 21f. LOCATION Street or R.F.D. No City or Town County State Beltsville P.G. Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE | | John Kehoe, M.D., Riverdale | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 8-21-68 |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | |
| 23a. BURIAL CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 8-24-68 | | Meadowridge Cemetery | | Wash. Blvd & Dorsey Rd. Balto Md. | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Howard H. Hubbard 4107 Wilkens Ave. 21229 | | | | | | DATE AUG 26 1968 | | Charles Judge |

MARY

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11088

CERTIFICATE OF DEATH

1968

Item 1d Film (1001 2/2/68)

| | | | |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGES b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CHEVERLY c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PRINCE GEORGES Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGES c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LANDOVER d. STREET ADDRESS 2512 COLUMBIA AVENUE | |
| 3. NAME OF DECEASED (Type or print) JOHN W MERKLE SR. | | 4. DATE OF DEATH Month AUGUST Day 27 Year 1968 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH JUNE 18, 1892 |
| 9. AGE (In years last birthday) 76 yrs. | | 10. IF UNDER 1 YEAR Months 7 Days 10 Hours 10 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER | | 10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME JOSEPH MERKLE | | 14. MOTHER'S MAIDEN NAME UNKNOWN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO. PAUL P. MERKLE SAME AS # 2 | |
| 17. INFORMANT PAUL P. MERKLE SAME AS # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Hypertensive Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 10 years DUE TO 10 years (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner.) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1957, to 8 Aug 1968, that (I) (we) last saw the deceased alive on 24 Aug 1968, and that death occurred at 11 AM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Dr. M. Hutcheson | | 22b. DATE SIGNED 8-27-68 | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 8-29-68 | |
| 23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY | | 23d. LOCATION (City, town or county) (State) SUITLAND, PRINCE GEORGES, MD. | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Wilhelm | | 25a. REC'D BY REGISTRAR AUG 30 1968 | |
| 24. FUNERAL HOME Wilhelm Funeral Home | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |
| 24. ADDRESS 4308 Suitland Road, Suitland, Maryland | | 25c. DATE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

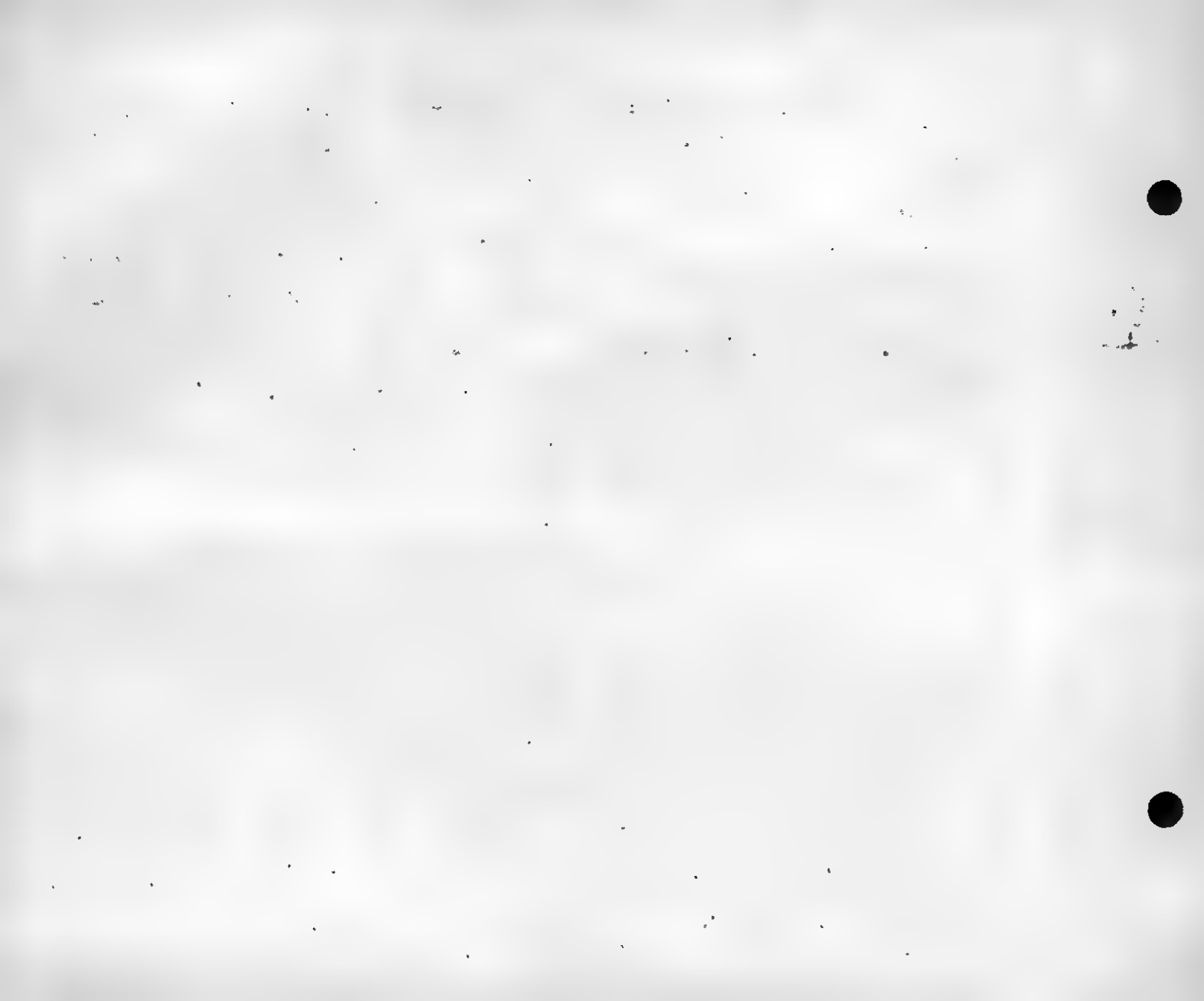


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VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--------------------------------|---|------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1 DECEASED NAME (Type or print) First Middle Last ETHEL Marie MERSON | | | | | | 2a. DATE OF DEATH Month Day Year AUGUST 16 1968 | | | 2b. HOUR 429 PM | | | | |
| 3. SEX F | | 4 RACE WHITE | | 5 DATE OF BIRTH Nov 28 1890 | | | 6 AGE (in years last birthday) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH PRINCE GEORGE Md. | | | | | | | |
| 10 CITY OR TOWN OF DEATH Riverdale | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) GERARD MEMORIAL | | | | 12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) HOUSEWIFE | | | | 12b. KIND OF BUSINESS OR INDUSTRY AT home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE MD. | | | | 13b. COUNTY P.G. | | 13c. CITY OR TOWN LAUREL | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 417 MAIN STREET. | | | |
| 14 FATHER'S NAME First Middle Last John J. CRESWELL | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Everline LIESURE | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service) No | | | | 16b. SOCIAL SECURITY NO ? | | 17 INFORMANT Address Mrs Raymond Wells Ellington Md | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) | | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary Thrombosis | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (b) Spasmodic Colon | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) Arthritis | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 420. | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTINUING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Bryan Pope Warren | | | | | | DEGREE ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE/SIGNED 8/16/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) BRYAN POPE WARREN | | | | | | 22e. ADDRESS 321 PRINCE GEORGE ST., LAUREL, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE 8-19-68 | | 23c. NAME OF CEMETERY OR CREMATORY Fry Hill | | | | 23d. LOCATION (City or Town) (County) (State) LAUREL Md. | | | |
| 24. FUNERAL DIRECTOR John R. Slack | | | | | | ADDRESS Ellington Md | | 25a. REC'D BY REGISTRAR DATE AUG 21 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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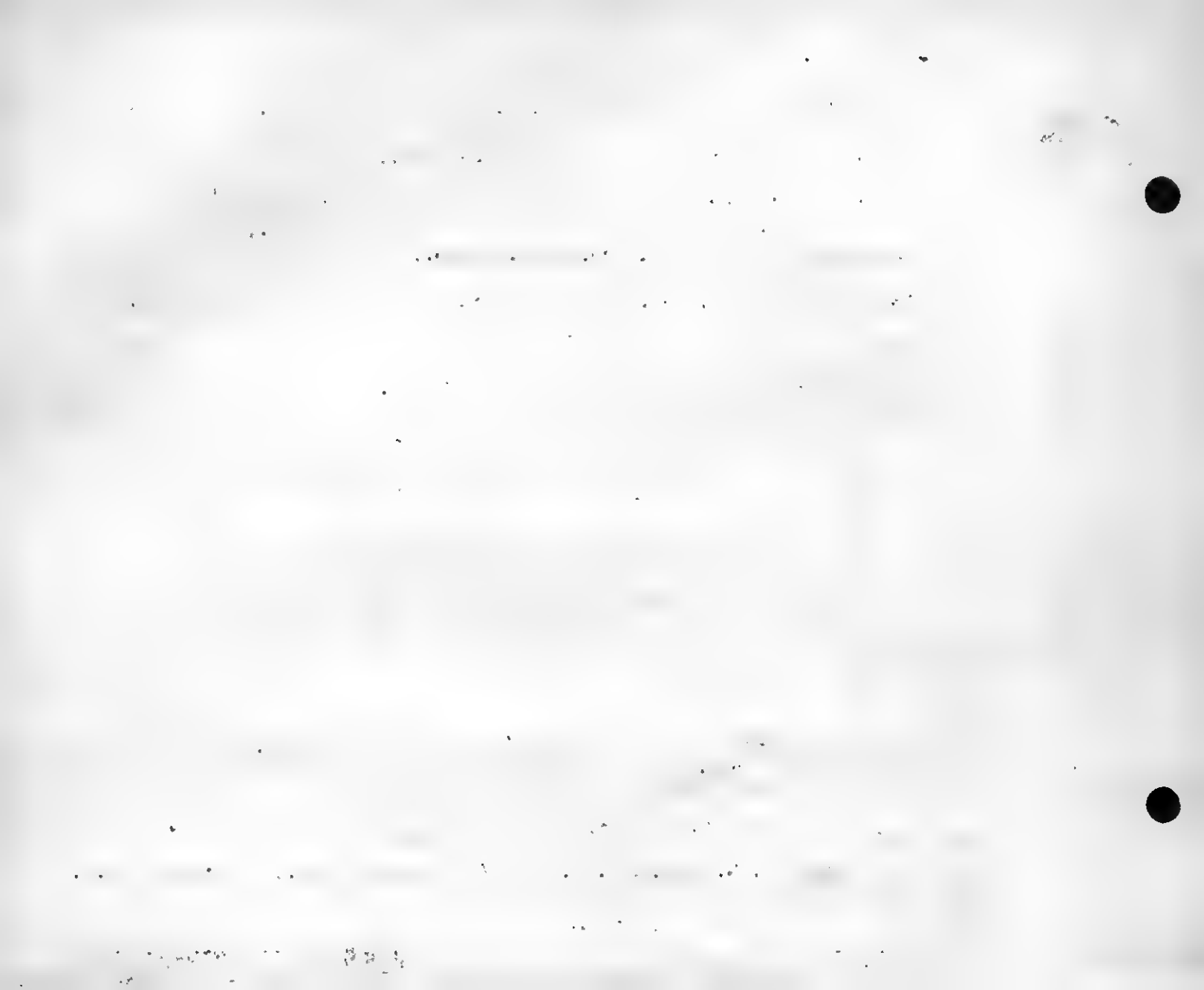
11990

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11068

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|---|--|---|------|--|--|--|-----------------------------------|---|--|
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR | | |
| Mary | | | First | Middle | Last | Aug. 5 1968 | | | 12, 05 AM | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6 AGE (In year last birthday) | | 7c. UNDER 1 YEAR MONTHS DAYS | | 7d. UNDER 24 HRS. HOURS MIN. | |
| Female | | White | | 26 Feb., 1880 | | 88 | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Wash. D.C. | | U.S.A. | | | | Prince George's Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | | Pr. Geo. Gen. Hosp. | | | Housewife | | | None | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INS. OF CITY, LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Pr. Geo. | | | Cottage City | | YES | | 3718 Parkwood St. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| Edward | | | McDermott | | | Susanah | | | Unk | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | |
| Yes, no, or unknown | | | None | | | 261 10 7135 | | | Robert W. Middleton Son | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Embolism</u> 4127 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 Days 3 Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) physician attended the deceased from <u>June 1, 1957</u> to <u>Aug. 5, 1968</u> , that (I) was lost sow the deceased alive on <u>Aug. 5, 1968</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Samuel J. N. Sugar, M.D.</u> | | | | | | 22c. DATE SIGNED <u>Aug 5, 1968</u> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Samuel J. N. Sugar, M. D. | | | | | | 22e. ADDRESS 4637 Eastern Ave., Washington, D.C. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 8/1968 | | Fort Lincoln Cemetery | | Colmar Manor, Md. | | | | | |
| 24. FUNERAL DIRECTOR Valley's Funeral Home Mt. Rainier, Md. | | | | | | 25a. REC'D BY REGISTRAR AUG 9 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-22a Film 404 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
1-25-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item# 2a Film 404

| | | | | | | | | | | | | | | | |
|---|--------|------------------------------|--------------------------------|---|------|-------------------------|-----|---|----------------|--|---------------------|--|--|--|--|
| 1. DECEASED NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | | 2b. HOUR | | | |
| Frederick | | | Wallace | | | Mitchel | | | 8 27 1968 | | | M | | | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR | | | | |
| Male | White | 1-11-1919 | 49 YRS | MONTHS | DAYS | HOURS | MIN | Month Day Year | | | 8 27 1968 19:38pm M | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CIT ZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | | | | |
| D.C. | | U. S. A. | | | | Prince George's Md | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cheverly | | | | Prince George Hospital | | | | Machinist | | | | U. S. A. | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| District of Columbia | | | | Washington | | | | | | | | 13e. STREET AND NUMBER | | | |
| | | | | | | | | | | | | 3222 5th. Street, S.E. | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| John A. Mitchell | | | | Selma Lloyd | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) | | | | 16b. SOCIAL SECURITY NO | | | | 17. INFORMANT | | | | ADDRESS | | | |
| Yes | | | | 5-09-644 | | | | John M. Mitchell | | | | D.C. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Combined intoxication - Alcohol and Carbon monoxide | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | |
| 722.1 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| | | | | 11:00AM 8-27-68 | | | | Connected hose from tail pipe to left rear window of car | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| | | | | Wooded area in rear of 1105 Rollins Ave. Capitol Hts. PG Md. | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | EXAMINER'S NAME (Type) | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED | | | |
| John Kehoe | | | | John Kehoe MD Riverdale, Md. | | | | | | | | 8-29-68 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | | 8-31-68 | | | | Cedar Hill Cemetery | | | | Smithfield Md. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| W. W. Chambers | | | | 6, 517-11 N.E. | | | | DATE SEP 3 1968 | | | | Charles Judge | | | |

CERTIFICATE OF DEATH

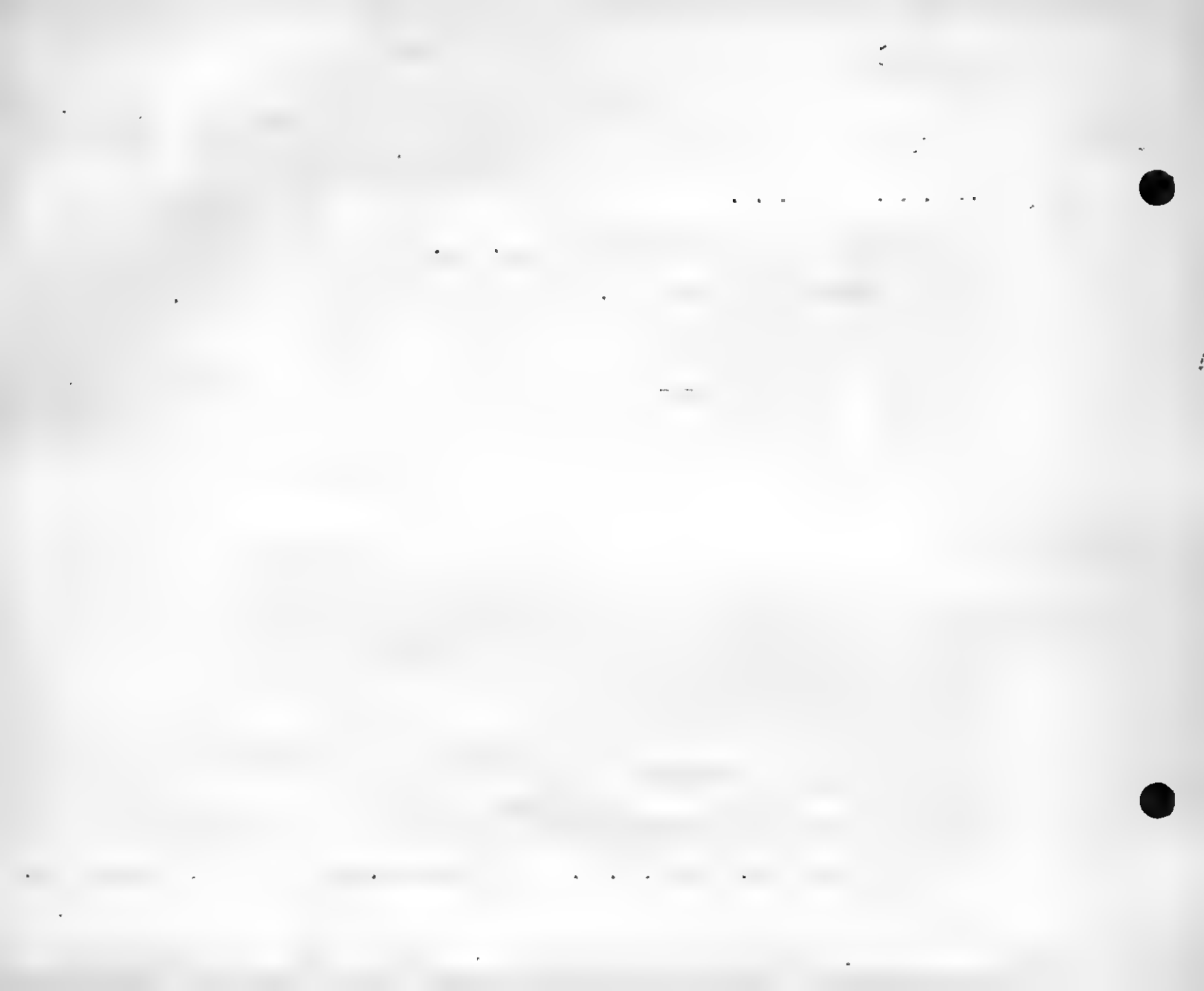
11992

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| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1 DECEASED NAME (Type or print) Baby Girl Regina Mitchem | | | 2a. DATE OF DEATH Month August Day 31 Year 1968 | | | 2b. HOUR 1:30p M | |
| 3 SEX Female | | 4. RACE White | | 5. DATE OF BIRTH August 21, 1968 | | 6. AGE (In years lost birthday) YRS. 10 MONTHS 10 DAYS 10 HOURS 10 MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Md., U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md. | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's Gen. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) -- | | 12b. KIND OF BUSINESS OR INDUSTRY -- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Prince Geo. | | 13b. CITY OR TOWN Colmar Manor | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 3603 38th Ave. | |
| 14 FATHER'S NAME First Richard B Middle Mitchem Last Mitchem | | | 15. MOTHER'S MAIDEN NAME First Vivian Middle Laudermilt Last Laudermilt | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. --- | | 17. INFORMANT Richard B Mitchem Address Colmar Manor, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) septicemia DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 7680 | | | | | | | |
| 19a. DATE OF OPERATION 7680 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (X) (this hospital) attended the deceased from August 21, 1968 , to August 31, 1968 , that (H) (we) last saw the deceased alive on August 31, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death xxx | | | | | | | |
| 22b. SIGNATURE Andrew G. Aronfy, M.D. | | | | 22c. DATE SIGNED Aug 31, 1968 | | 22d. PHYSICIAN'S NAME (Type) Andrew G. Aronfy, M.D. | |
| 22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md. | | | | 22f. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Sept 4, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | |
| 24 FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Md. | | 25a. REC'D BY REGISTRAR SEP 5 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|--|--|---|---|--|---|--|----------------------------|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 11993 CERTIFICATE OF DEATH 12001 | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR a | | | |
| Anna | | | Gertrude | Moan | August 6 1968 | | 11:30 PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | | |
| Female | | White | | July 28, 1879 | | 89 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| New York | | United States | | | | Prince George Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hyattsville | | | Sacred Heart Home | | | Housewife | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Montgomery | | Chevy Chase | | YES | | 4819 Cumberland Avenue | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| James | | | Burns | | | Mary | | | Unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| No | | | 220-44-7249 | | | Sacred Heart Home, Hyattsville, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) ARTERIOLECTIC HEART D. WITH AC. POLY. FROM | | | | | | | | | 36 hrs. | | |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| (b) ARTERIOLECTIC GEN + CEREBRAL | | | | | | | | | 2 yrs. | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 4 yrs. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT, 1966, to AUG, 1968, that (I) (we) lost saw the deceased alive on AUG. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Leo M. Curtis | | | | | | | | | | 8-6-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| LEO M. CURTIS, M.D. | | | | | | 1212 WILSON AVE, BETHESDA, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 8/9/68 | | Saint James Cemetery | | | Belvidere, Boone Illinois | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert P. Humphrey | | | | | | Bethesda, Md. | | AUG 13 1968 | | Charles Judge | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11994

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12002

| | | | | | | | | | | | | | | | | | |
|---|---|-----------------------------|---|---|-------------|--------------------------------|----------|---|--------|-------------------------|--------|---|--|--------------------------------|--|---------|--|
| 1 DECEASED NAME (Type or Print) | | First | | Middle | | Last | | 2a DATE KNOWN OF EST. DEATH MATED <input checked="" type="checkbox"/> 8 31 1968 | | | | 2b HOUR a M 1:30 | | | | | |
| George | | Fremonet | | Morgan | | | | | | | | | | | | | |
| 3 SEX | M | 4 RACE | W | 5 DATE OF BIRTH | 19 May 1915 | 6 AGE (In years last birthday) | 53 YRS 4 | 7 IF UNDER 1 YEAR MONTHS | 8 DAYS | 9 IF UNDER 24 HRS HOURS | 10 MIN | 2c DATE PRONOUNCED DEAD Month 8 Day 31 Year 1968 | | 2d HOUR a M 1:53 | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | | | | | | | | | |
| Maryland | | U.S.A. | | | | Prince George | | Md | | | | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | | 12a L.S.A. OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | | |
| Cheverly | | | | Prince George Hosp | | | | Baker | | | | Grocery | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | | | 13b COUNTY | | | | 13c CITY OR TOWN | | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER | | | |
| Md. | | | | Prince George Mt. Rainier | | | | | | | | 3370 Chillum Rd. | | | | | |
| 14 FATHER'S NAME First Middle Last | | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | |
| Lewis C. Morgan | | | | Mamie Jones | | | | | | | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b SOCIAL SECURITY NO | | | | 17 INFORMANT | | | | ADDRESS | | | | | |
| No | | | | 579 03 9085 | | | | Edith L Morgan | | | | same as above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) | | | | | | | | | | | | Heart failure | | Minutes | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | | | (b) | | Arteriosclerotic heart disease | | Unknown | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | John Kehoe, M.D., Riverdale | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) | | | | 22b DATE SIGNED 9-2-68 | | | | | |
| EXAMINER'S NAME (Type) | | | | | | | | | | | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL, (Specify) | | | | 23b DATE | | | | 23c NAME OF CEMETERY OR CREMATORY | | | | 23d LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | | 9/3/1968 | | | | Baltimore National Cem, Baltimore, Maryland | | | | | | | | | |
| 24 FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a REC'D BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | | | |
| Valley's Funeral Home | | | | St. Rainier, Md. | | | | DATE SEP 5 1968 | | | | J Charles Judge | | | | | |

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11995

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12003

CERTIFICATE OF DEATH

| | | | | | | | | |
|--|------------------------------|---|--|--|-------------------------------------|--|--------------------------------|--|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | |
| DOROTHY | | NAOMI | MURPHY | | AUG 1 1968 | | 4:28 P | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| FEMALE | CAUC | | 10 Nov 1902 | | 65 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| PENNSYLVANIA | U.S.A. | | | | PRINCE GEORGE'S Md | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| HILLCREST HGTS | | 3107 GOOD HOPE AVE | | HOUSEWIFE | | NA | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MD | | PRINCE GEORGES HGTS | | | | 3107 GOOD HOPE AVE | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | First Middle Last | | | | | | |
| MAURICE | | WARING | | ANNA WISE | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT (SON) | | Address | | |
| NO | | 160-42-1288 | | PATRICK J. MURPHY | | SAME AS ITEM #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) INTROCEREBRAL BLEEDING AND/OR OCCLUSION | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) VASCULAR INSUFFICIENCY OF BASILAR ARTERY | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC SMOLDERING HEPATITIS | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ALCOHOLISM, PULMONARY INSUFFICIENCY | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC.) | | 21c. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | |
| GEORGE D. CIMOCHOWSKI, MD | | | | | | 1 AUG 68 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| | | 8-5-68 | | Piedmont Natl. Cem. | | San Francisco California | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| W. W. Chambers | | 517-11 St. N.E. | | DATE AUG 8 1968 | | J. Charles Young | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 18169 | | |
|--|--------|-----------------------------|---|--|------|--|------|-------------------------|---|--------|---------|---------|
| 1 DECEASED NAME (Type or Print) | | | First | Middle | Last | 2a DATE KNOWN OF DEATH | | | Month | Day | Year | 2b HOUR |
| RICHARD ANTHONY NELSON | | | | | | ESTIMATED <input checked="" type="checkbox"/> 8/19/68 | | | 19 | 24 | 1968 | P. M. |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD | | | 2d HOUR | |
| male | white | 7/26/42 | 26 YRS | MONTHS | DAYS | HOURS | M.N. | Month Day Year | | | 12 noon | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | |
| Washington D C | | U S A | | | | Prince George's Md. | | | | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| Riverdale Unknown | | | State Rt. 408 Chambers Funeral Home | | | Clerk | | | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| Maryland | | | Prince Georges | | | Palmer Park | | | 8414 A. 80th Avenue | | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15 MOTHER'S MAIDEN NAME | | | First | Middle | Last | |
| George A Nelson | | | | | | Alma H Smith | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO. | | | 17 INFORMANT | | | |
| | | | | | | | | | Robert L Pritchett | | | |
| | | | | | | | | | ADDRESS Herndon Va | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Gunshot Wound of Head | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | |
| 981X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| | | | 24 HOUR A.M. P.M. 8/19/ 19 68 | | | Unknown | | | | | | |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No City or Town State County 408 State | | | | | | |
| | | | Unknown | | | Unknown (Found off north side of) | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | EXAMINER'S NAME (Type) | | | 22b DATE SIGNED | | | | | | |
| | | | Werner U. Spitz, M.D. | | | 1/8/69 | | | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d LOCATION (City or Town) (County) (State) | | | |
| Burial | | | Jan 13, 1969 | | | Mt Olivet Cemetery | | | Washington D C | | | |
| 24 FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | | 25b REGISTRAR'S SIGNATURE | | | |
| F. Gasch's Sons | | | Hyattsville, Md. | | | JAN 14 1969 | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|------|--|--|--|--|
| DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 11996 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH | | 2b. HOUR | |
| Ernest D. Norris | | | | | | August 23, 1968 | | 4:50AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | 7. IF UNDER 1 YEAR | |
| Male | | Caucasian | | April 22, 1881 | | 87 YRS. | | MONTHS 4 DAYS 1 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | | Prince Geo. Gen'l Hospital | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. STREET AND NUMBER | |
| Maryland | | | Prince George's | | | Wheaton | | Box 20 Waterloo Road University Nursing Home | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | |
| | | | | | | First Middle Lost | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | |
| No | | | 213-16-2652A | | | Grace Mullineaux 114 S. VanBuren St. Rockville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emboli</u> 4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio-Vascular disease</u> 10 years DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterial Obstruction of Left Leg with Gangrene</u> 3-4 months | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 7/31/68 | | amputation of leg - gangrene | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) <u>do not</u> attended the deceased from <u>Aug. 23, 1968</u> , to <u>Aug. 23, 1968</u> , that (I) <u>was</u> lost saw the deceased alive on <u>Aug. 23, 1968</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>William Brainin</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED <u>8/23/68</u> | | | |
| 22a. PHYSICIAN'S NAME (Type) <u>WM BRAININ</u> | | | | | | 22e. ADDRESS <u>6056 Central Ave, Capitol Hill Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) Md. | | | |
| BURIAL | | August 26, 1968 | | Parklawn | | Rockville, Montgomery, | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| <u>Karen G. Humphrey</u> | | <u>7557 Newcomen Ave Bethesda, Md.</u> | | DATE <u>AUG 30 1968</u> | | <u>Charles Judge</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-58

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | |
| Ruth Fletcher Oliff | | | | | | August 7 1968 | | 4:25 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | Dec. 20, 1893 | | 74 YRS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Washington, D. C. | | U.S.A. | | | | Prince Georges Md | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hyattsville, Md. | | Hyattsville Nursing Home | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Anne Arundel | | Shadyside | | | | Box 42 | |
| 4. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Richard H Talbott | | | Rachel Fletcher | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO (If yes give year or dates of service) | | 17. INFORMANT Address | | | | |
| | | | 577 12 0889 | | Helen R Reid 5615 35 ave Hyattsville Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial infarct</u> | | | | | | | | 1 hr | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| <u>4201 metastatic brain tumor</u> | | | | | | | | | |
| 9a. DATE OF OPERATION | | 9b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7/30</u> , 19 <u>68</u> , to <u>Aug 7</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/7</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Myron L Lenkin</u> | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED <u>8/7/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Myron L Lenkin</u> | | | | 22e. ADDRESS <u>Wheaton, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Aug 10, 1968 | | Pt Lincoln Cemetery | | Colmar Manor Pro Geo Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| F. Gasch's Sons Hyattsville, Md. | | | | AUG 12 1968 | | <u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

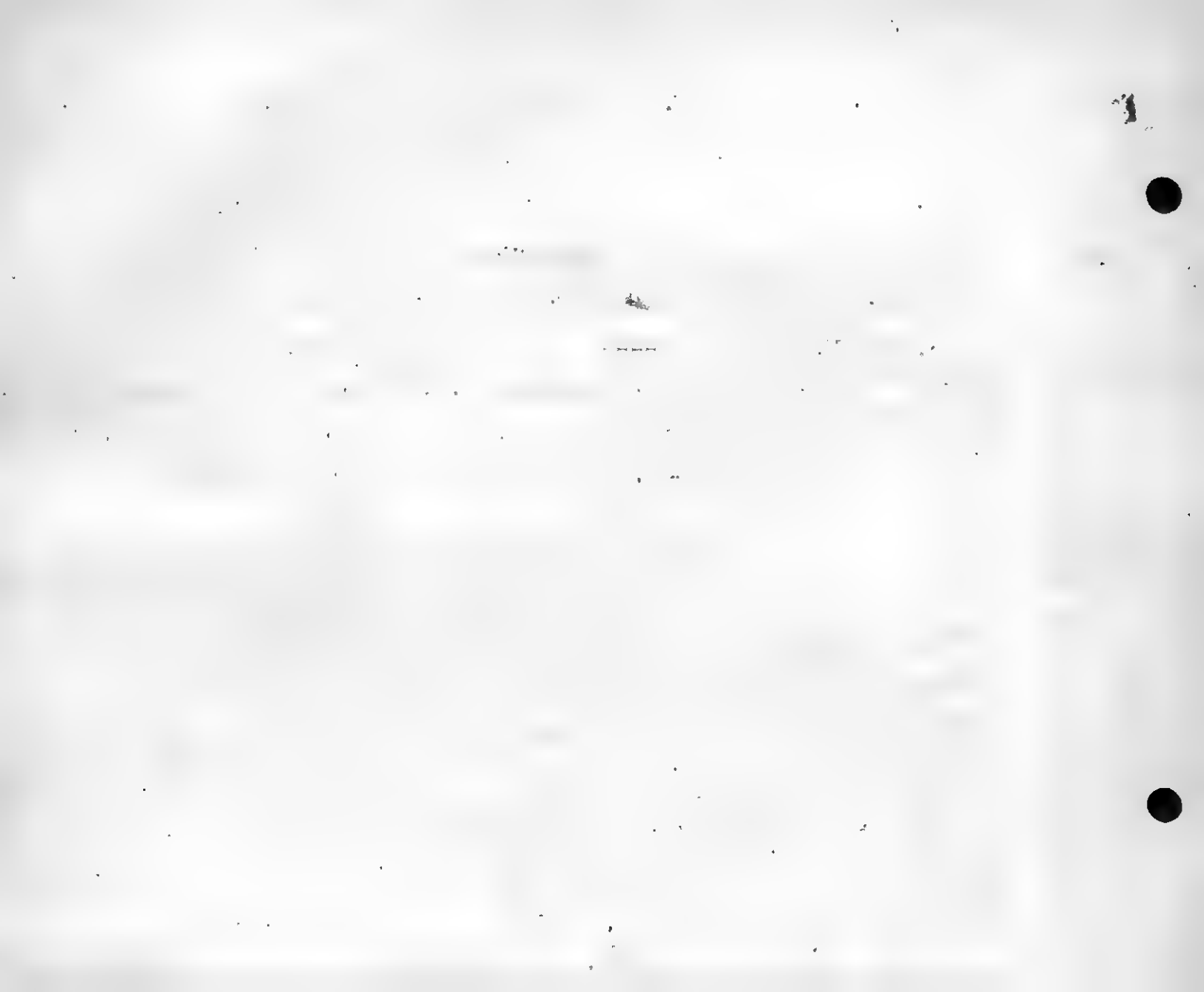
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11398

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11398

| | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|--|
| 1 DECEASED-NAME (Type or print) Mary | | | First Middle Last M. Parks | | | 2a. DATE OF DEATH Month Day Year August 29 68 | | | 2b. HOUR 9:15pM | | |
| 3 SEX Female | | | 4 RACE white | | | 5. DATE OF BIRTH 3/31/86 | | | 6 AGE (In years last birthday) 82 YRS | | |
| 7a BIRTHPLACE (State or foreign country) Md. | | | 7b CITIZEN OF WHAT COUNTRY? USAN | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Prince Georges Md. | | |
| 10 CITY OR TOWN OF DEATH Riverdale | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housekeeper | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | | 13b COUNTY Prine G | | | 13c CITY OR TOWN Berwin Heights | | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e STREET AND NUMBER 8914 58th Avenue | | | 14 FATHER'S NAME First Middle Last Geo. Farrell Parks | | | 15. MOTHER'S MAIDEN NAME First Middle Last Theresa Quade | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b SOCIAL SECURITY NO. 218-30-3481 | | | 17 INFORMANT daughter | | | Address Helen L. Mullican 8914 58th Avenue Berwin Hgts. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) THROMBOSIS OF CORONARY ARTERY DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) + | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-29 , 19 68 , to 8-29 , 19 68 , that (I) (we) last saw the deceased alive on 8-29 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. DR. J. K. ... | | | | | | | | | | | |
| 22b. SIGNATURE C. J. HOUMANN | | | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 8-29-68 | | |
| 22d. PHYSICIAN'S NAME (Type) C-J. HOUMANN M.D. | | | | | | 22e. ADDRESS RIVERDALE | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) burial | | | 23b. DATE 9/3/68 | | | 23c. NAME OF CEMETERY OR CREMATORY Wash. Nat. Cem. | | | 23d. LOCATION (City or Town) (County) (State) Suitland, Md. | | |
| 24. FUNERAL DIRECTOR Nalley's Funeral Home Inc. | | | | | | ADDRESS 1111 Main St. | | | 25a. REC'D BY REGISTRAR DABEP 5 1968 | | |
| | | | | | | | | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. 5 may be retained for your files.

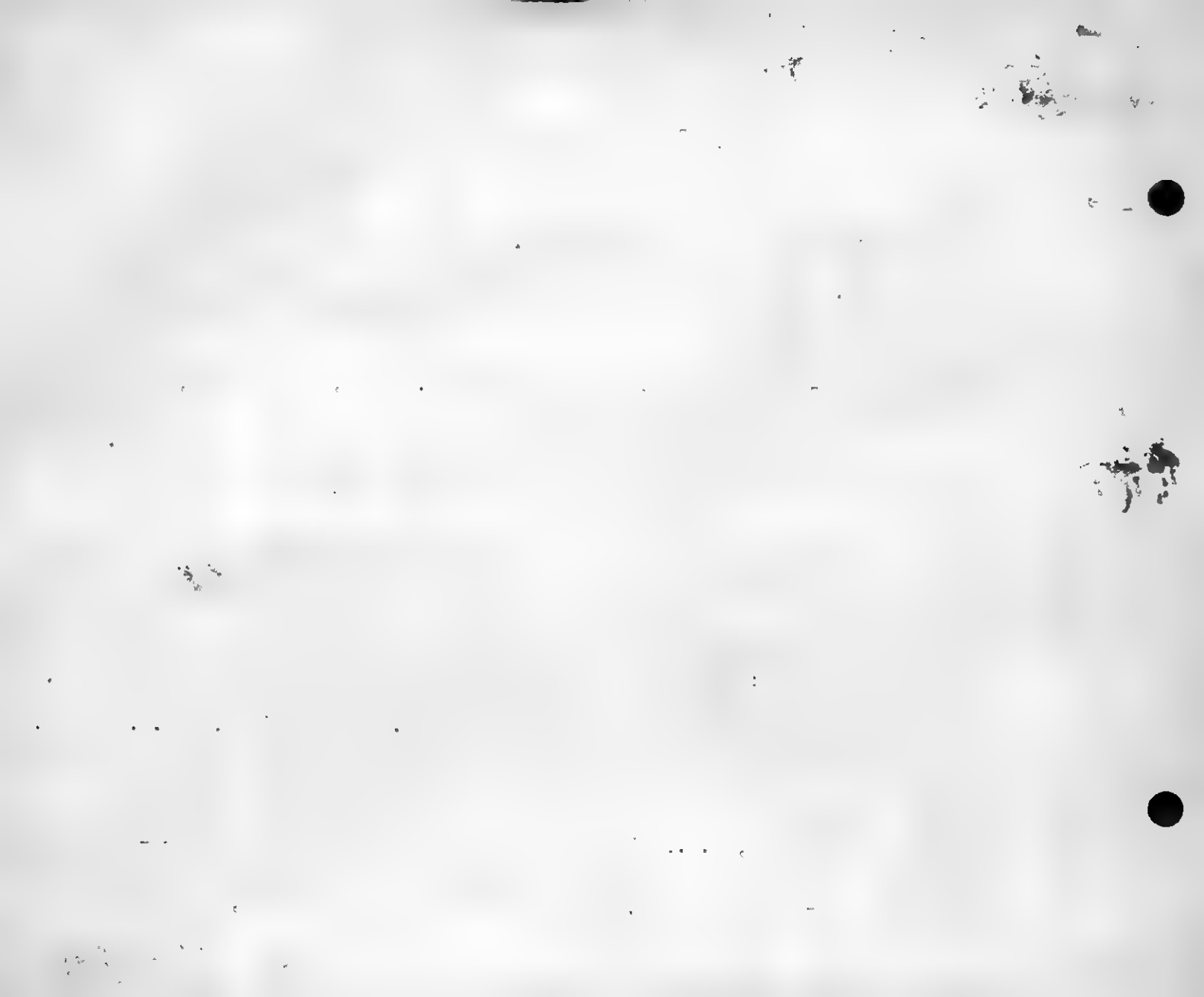
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File, pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

11999

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | |
|---|--------------------|--|---|---|--|---|--|--|--|---|
| 1. DECEASED-NAME (Type or Print) Luther A Peden | | | 2a. DATE KNOWN OF DEATH Month 8 Day 3 Year 1968 | | | 2b. HOUR 12:01 a.m. | | | | |
| 3 SEX M | 4 RACE W | 5 DATE OF BIRTH 1/29/1904 | 6 AGE (in years last birthday) 40 YRS | 7 IF UNDER 1 YEAR MONTHS 0 DAYS 0 | 8 IF UNDER 24 HRS HOURS 0 MIN 0 | 2c. DATE PRONOUNCED DEAD Month 8 Day 3 Year 1968 | | | 2d. HOUR 12:10 a.m. | |
| 7a. BIRTHPLACE (State or foreign country) Alabama | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George | | | | |
| 10. CITY OR TOWN OF DEATH Andrews Air Base | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) AAFB Hosp. | | | 12a. USIA. OCCUPATION (Kind of work done during most of working life, even if retired) Fireman | | | 12b. KIND OF BUSINESS OR INDUSTRY US Gov't | |
| 13a. USIA. RESIDENCE (Where deceased lived, if institution admission) STATE Md. | | | 13b. COUNTY Prince George | | | 13c. CITY OR TOWN Oxon Hill | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 5006 Jaywick Court |
| 14. FATHER'S NAME First Jack Middle Peden Last Peden | | | 15. MOTHER'S MAIDEN NAME First Unknown Middle Unknown Last Unknown | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (if yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. Unknown |
| 17. INFORMANT Barbara A. Peden, Same as #13, (Wife) | | | ADDRESS Barbara A. Peden, Same as #13, (Wife) | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral hemothorax 816.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple rib fractures DUE TO, OR AS A CONSEQUENCE OF (c) Trauma-auto accident | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:01 a.m. 8 3 19 68 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Passenger in car which collided with pole. | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street | | | 21f. LOCATION Street or R.F.D. No. City or Town County State Allentown Rd., Camp Springs, P.G. Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe, M.D., Riverdale | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 8-3-68 | | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 8-6-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery | | | 23d. LOCATION (City or Town) (County) (State) PG County, Maryland | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home ADDRESS 4308 Suitland Rd/ SE, Suitland, Maryland | | | | | | 25a. REC'D BY REGISTRAR DATE AUG 12 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4, page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) First Middle Last William P Pike | | | 2a. DATE OF DEATH Month Day Year Aug 14, 1968 | | | 2b. HOUR 2:45 AM | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH Aug 10, 1885 | | 6. AGE (In years last birthday) 83 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Arkansas | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md. | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Manor | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Proof Reader Govt Printing Office | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admision) STATE Md | | 13b. COUNTY Pro Geo | | 13c. CITY OR TOWN Hyattsville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 1902 Van Buren Street | | | | | | | |
| 14. FATHER'S NAME First Middle Last Alonzo Pike | | | 15. MOTHER'S MAIDEN NAME First Middle Last Frances Wight | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | | 16b. SOCIAL SECURITY NO 219 48 3214 | | 17. INFORMANT Marion P Grimes | | Address Hyattsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Type of many years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Has had series of C.V.A. past several yrs.; Senile Brain Syndrome.</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 2, 1964</u> , to <u>8/14, 1968</u> , that (I) (we) lost saw the deceased alive on <u>8/13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <u>Roger S. Williams M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>8/14/68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>ROGER S. WILLIAMS</u> | | | | 22e. ADDRESS <u>35 NEW YORK AVE. N.W.</u> | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> | | 23b. DATE Aug 16, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Suitland Pro Geo Md. | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | ADDRESS Hyattsville, Md | | 25a. REC'D BY REGISTRAR AUG 16 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30A REV

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|--|--|--|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Robert | | | Middle Pittman | | | Last | | | 2a. DATE OF DEATH Month August Day 30 , Year 1968 | | | 2b. HOUR 2:45PM | | |
| 3. SEX Male | | | 4. RACE Colored | | | 5. DATE OF BIRTH 12/25/95 | | | 6. AGE (In years last birthday) 72 YRS. | | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | | IF UNDER 24 HRS HOURS 0 MIN. 0 | | |
| 7a. BIRTHPLACE (State or foreign country) Georgia | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Prince George's Md | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY 1 | | | 13c. CITY OR TOWN Waldorf | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER Rt. 1, Box 143 | | | | | |
| 14. FATHER'S NAME First Robert | | | Middle B. Pittman | | | Last | | | 15. MOTHER'S MAIDEN NAME First Unknown | | | Middle Unknown | | | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Joseph H. Pittman - Same as above Address | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1. TERMINAL CHRONIC CARDIOVASCULAR DISEASE 127 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PROSTATE DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | | 21f. LOCATION Street or RFD No City or Town County State | | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 29, 1968 , to August 30, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 30, 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Saul W. Rosen | | | DEGREE M. D. | | | ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED 8/30/68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Saul W. Rosen, M. D. | | | 22e. ADDRESS Prince George's General Hospital Cheverly, Maryland | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Sept. 4/68 | | | 23c. NAME OF CEMETERY OR CREMATORY St. Peter's Ch. Cem. | | | 23d. LOCATION (City or Town) (County) (State) Waldorf Chas. Co. Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR Thomas Turner | | | ADDRESS Thomas Turner, 1000 N. ... | | | 25a. REC'D BY REGISTRAR SEP 6 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | |



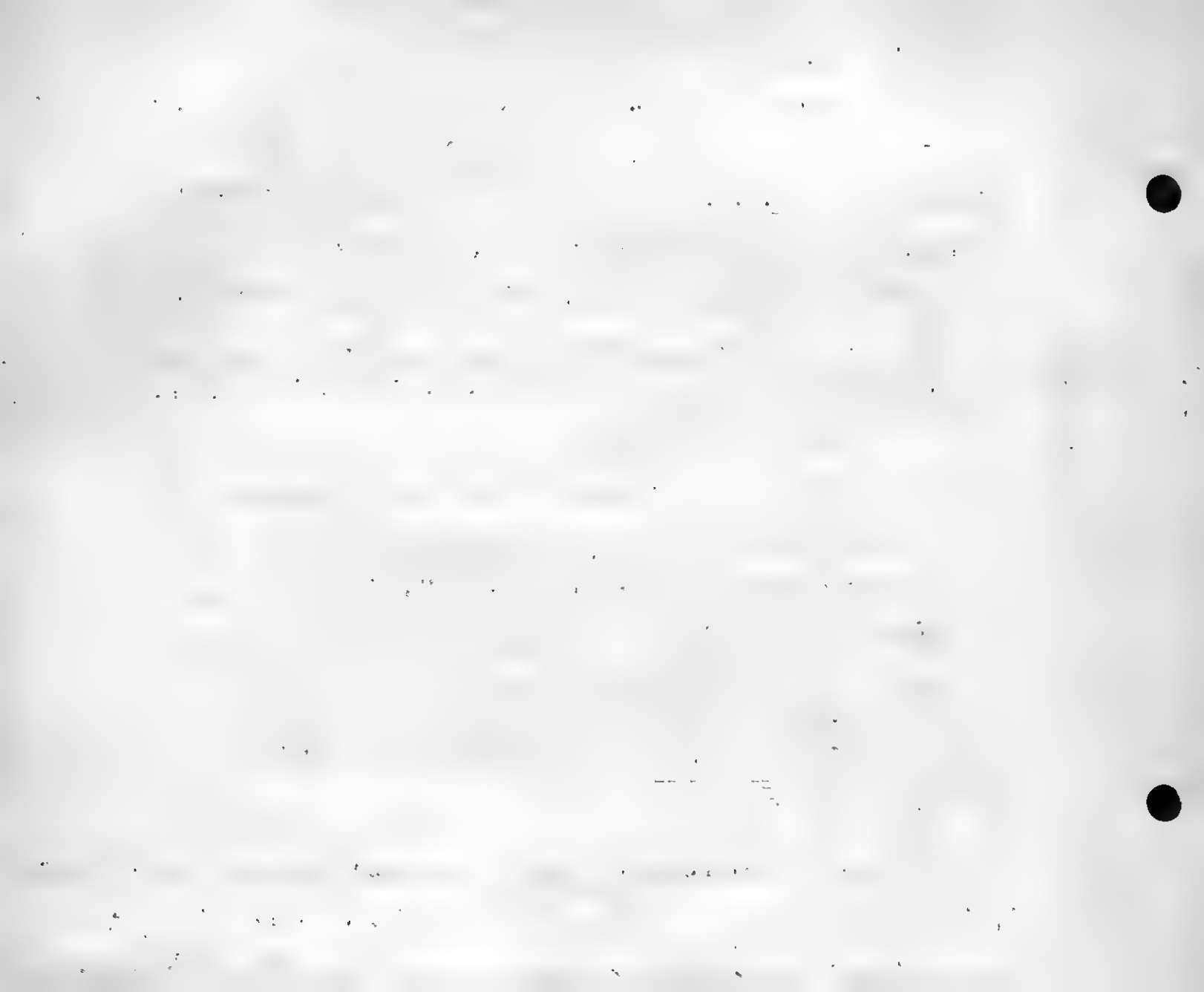
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | |
|---|--|---|--|---|
| 1 DECEASED-NAME (Type or print) Blanch L. Pletcher | | 2a. DATE OF DEATH Month Aug Day 1 Year 1968 | | 2b. HOUR 6:05 PM |
| 3. SEX Female | 4 RACE Caucasian | 5. DATE OF BIRTH 11 Sep 1879 | | 6. AGE (In years last birthday) 89 YRS. |
| 7a. BIRTHPLACE (State or foreign country) Missouri | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH PRINCE GEORGE'S Md | |
| 10. CITY OR TOWN OF DEATH Andrews AFB | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAF Hosp | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MO | 13b. COUNTY Franklin | 13c. CITY OR TOWN Pacific | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER Union St. |
| 14. FATHER'S NAME First Middle Last C. C. CLOSE | 15. MOTHER'S MAIDEN NAME First Middle Last NELLIE HENRY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO | 16b. SOCIAL SECURITY NO | 17. INFORMANT 28 Westover Ave Bolling MRS K. E. PLETCHER AFB D.C. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration 4389 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 2388 (b) Arteriosclerotic cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (1) (a) Intertrochanteric fracture incurred July 17, 1968 | | | | |
| 19a. DATE OF OPERATION 18 July 68 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Hip fracture | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (H) (this hospital) attended the deceased from July 7, 1968 , to Aug 1, 1968 , that (H) (we) last saw the deceased alive on Aug 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Alan G. Herrington | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22c. DATE SIGNED 1 Aug 68 | | |
| 22d. PHYSICIAN'S NAME (Type) ALAN G HERRINGTON MAJ USAF | 22e. ADDRESS MC MALCOMM GROW USAFH ANDREWS AFB | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE 8-2-68 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | 23d. LOCATION (City or Town) (County) (State) WILKESVILLE MARYLAND | |
| 24. FUNERAL DIRECTOR W. B. Helm Funeral Home | 25a. REC'D BY REGISTRAR DATE AUG 3 1968 | | 25b. REGISTRAR'S SIGNATURE John Charles Judge | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 3403. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|-------------|---|--------------|---|--|---|------------|--|------------|---|---|
| 1 DECEASED NAME (Type or Print) | | First Andrew | Middle H. | Last Prigmore | 2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <input type="checkbox"/> | | Month 8 | Day 21 | Year 68 | 2b HOUR 5:50 P M | |
| 3 SEX M | 4 RACE W | 5 DATE OF BIRTH 1921 10 Oct 1921 | | 6 AGE (in years last birthday) 46 YRS | 7 UNDER YEAR MONTHS DAYS HOURS MIN | 2c DATE PRONOUNCED DEAD Month 8 Day 21 Year 1968 | | 2d HOUR 6:25 P M | | | |
| 7a BIRTHPLACE (State or foreign country) Tenn. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Prince George Md | | | | | |
| 10 CITY OR TOWN OF DEATH Cheverly | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hosp | | | 12a USUA. OCCUPATION (Kind of work done during most of working life even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md. | | 13b COUNTY Prince George Cap Heights | | 13c CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e STREET AND NUMBER 817 51st St., N.E. |
| 14 FATHER'S NAME First Middle Last James A. Prigmore | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Rosa Colloway | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | (If yes give war or dates of service) WW 2 | | 16b SOCIAL SECURITY NO | | 17 INFORMANT Mattie Bailey | | ADDRESS 159 E. Bell St Alcoa Tenn | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia during 3402 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Grand Mal Seizure DUE TO, OR AS A CONSEQUENCE OF (c) Epilepsy | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes 3 yrs. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) | | John Kehoe, M.D., Riverdale | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b DATE SIGNED 8-22-68 | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) | | 23b DATE 8-27-68 | | 23c NAME OF CEMETERY OR CREMATORY Baltimore Nat | | 23d LOCATION (City or Town) Baltimore Md | | (County) (State) | | | |
| 24 FUNERAL DIRECTOR H.S. Washington & Son - 4935 Deane Ave NE | | | | ADDRESS DC | | 25a REC'D BY REGISTRAR DATE AUG 26 1968 | | 25b REGISTRAR'S SIGNATURE Charles Judge | | | |

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

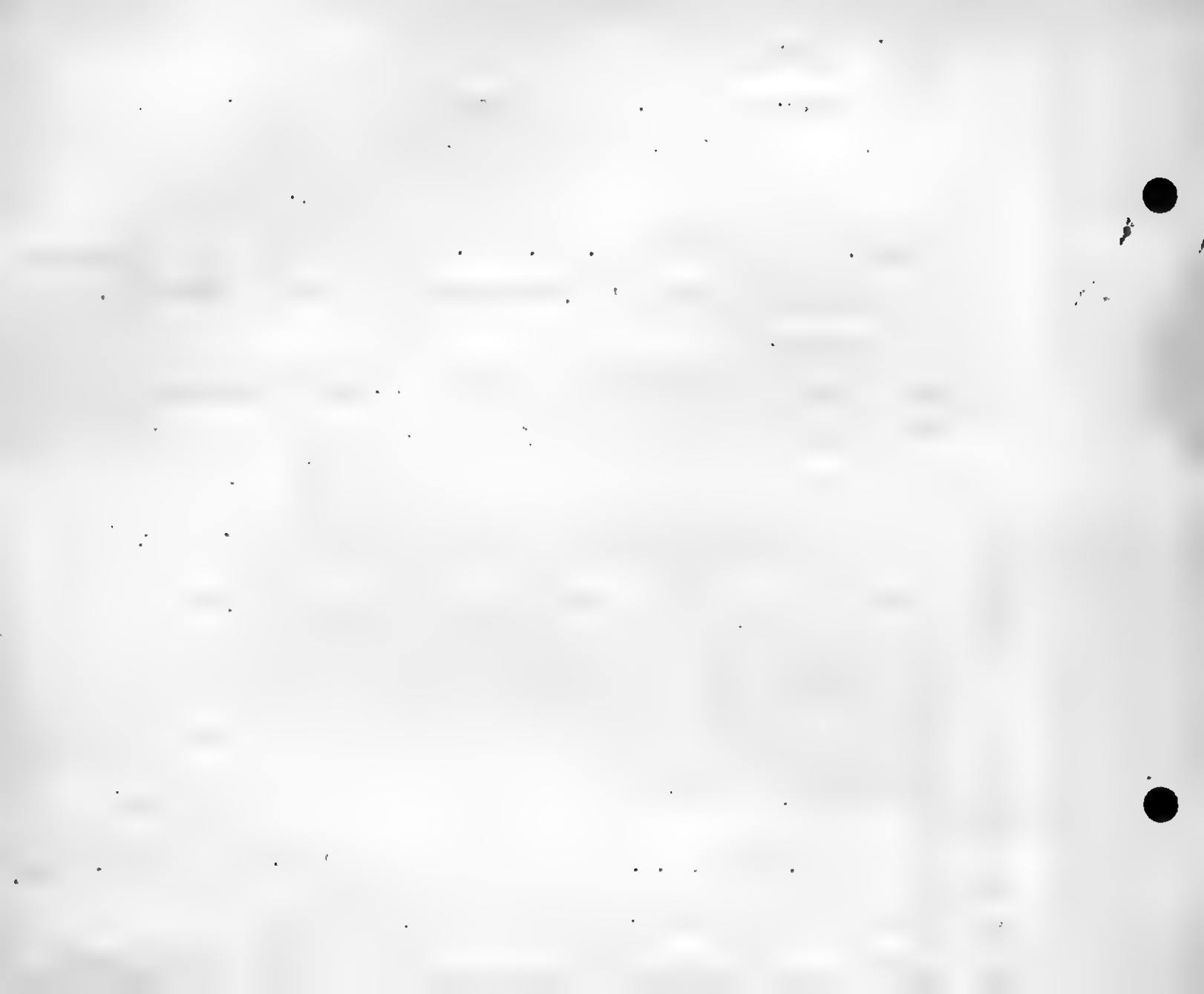
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--------|------------------------------|--|--|-------------------|---|--|---|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or Print) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | | 2c. DATE PRONOUNCED DEAD |
| John Eugene Proctor | | | 8-13-68 | | | 19:42am | | | 6810:45am |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6 AGE (in years last birthday) | 7 UNDER 1 YEAR | 8 IF UNDER 24 HRS | | | | |
| Male | Negro | 2-17-1938 | 30 YRS | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| Washington, D.C. | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Prince George's Md | | | |
| 10. CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | 12b KIND OF BUSINESS OR INDUSTRY |
| Cheverly | | | Prince George General Hosp. | | | | | | |
| 13a U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) - STATE | | | 13b COUNTY | | | 13c CITY OR TOWN | | | 13d INSIDE CITY, APTS? |
| Maryland | | | Prince George's | | | Oxon Hill | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14 FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Roger F Proctor | | | Mary A. Proctor | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| | | | | | | Mary A. Proctor | | | |
| | | | | | | ADDRESS 6528 Bock Road | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of chest | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day, Year | | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | 9:40am 8-13-68 | | | Shot self with .12 gauge shot gun. | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | | 21f LOCATION Street or R.F.D. No City or Town County State | | | |
| | | | 5442 Oxon Hill Road (driveway) Oxon Hill, Prince George Co., Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | ASS STANT MEDICAL EXAMINER | | | 8-14-68 | | | |
| John Kehoe MD Riverdale, Md. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | |
| | | | ADDRESS (Street, city, town, or county) | | | | | | |
| 23a B. BURIAL CREMATION, RESPECUALLY (Specify) | | | 23b DATE | | | 23c NAME OF CEMETERY OR CREMATORY | | | 23d. LOCAT ON (City or Town) (County) (State) |
| Burial | | | 8/17/68 | | | St. Ignatius Catholic Church | | | Oxon Hill, Md. |
| 24 FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Stewart Funeral Home-4001 Benning Rd. N.E. | | | AUG 19 1968 | | | James H. Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--------|---|---|---|--------------------------------|---|--|---|--|
| 12005 CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Roderick | | | H. Purks | | | May 30 68 | | | 10:00 PM |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | | 6 AGE (in years last birthday) | IF UNDER YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| Male | White | 4/27/06 | | | 62 | YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Va | | U S A | | | | Prince George's Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | | Prince Geo. Gen. Hosp. | | | Mechanic | | Automobiles | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INS. DE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | Prince George's | | | W. Hyattsville | | 3906 Queensbury Rd. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| John Purks | | | Cora | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17. INFORMANT | | | |
| Yes | | | W W 11 | | | Charlotte G. Purks W Hyattsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory failure</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic pulmonary disease</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Brain tumor (astrocytoma; grade III)</u> | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) | | | | | | | | | |
| 1936 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 8/19/68 | | Brain tumor | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/19/68 to 8/30/68, that (I) (we) last saw the deceased alive on August 28, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| Ruth K. Jakoby, M.D. | | 8-31-68 | | Prince George's General Hospital, Cheverly Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Sept 3, 1968 | | Christ Church Cemetery | | Chaptico Md | | | |
| 24. FUNERAL DIRECTOR | | 24a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| F. E. Sacks, Jr., Hyattsville, Md. | | SEP 4 1968 | | Charles Judge | | | | | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 13. Page 5 may be retained for your files.

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12008 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

VR A15ME (5)
10M REV 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|-----------------------------------|--|--|--|--|--|--|--|
| 12007 CERTIFICATE OF DEATH 10015 | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | 2b. HOUR | | | | | |
| Mattie | | M | | Randall | | 8 | | Month 14 Day 68 | | 37 M | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | | | | |
| Female | | Colored | | 02-02-70 | | | | 98 YRS. | | MONTHS DAYS HOURS MIN | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | Md. | | | | | |
| Georgia | | U.S.A. | | | | Prince Georges | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Hyattsville | | Hyattsville Nursing Home | | | | Housewife | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | | | |
| Wash., D. C. | | N.E. | | Wash., D. C. | | | | 1356 E. Capitol St., N. E. | | | | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | | | | | |
| Unknown | | | | | | | | Unknown | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT | | Address | | | | | | | |
| | | | | 579-52-4775 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> | | | | | | | | | | 2 months | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> | | | | | | | | | | Unknown | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>General arteriosclerosis</u> | | | | | | | | | | Unknown | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC | | 21f. LOCATION Street or RFD No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1968</u> , to <u>Aug 14, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 14, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | 22b. SIGNATURE <u>Henry G. Hadley</u> | | 22c. DATE SIGNED <u>Aug 14 68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>H. G. HADLEY</u> | | | | | | | | | | 22e. ADDRESS <u>4601 NICHOLS AVE NW</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE <u>8-17-1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Mem. Cem</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Suitland Md.</u> | |
| 24. FUNERAL DIRECTOR <u>H.S. Washington</u> | | | | | | | | | | ADDRESS <u>4425 Duane Ave</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3, Page 5 may be retained for your files.

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MEDICAL CERTIFICATION

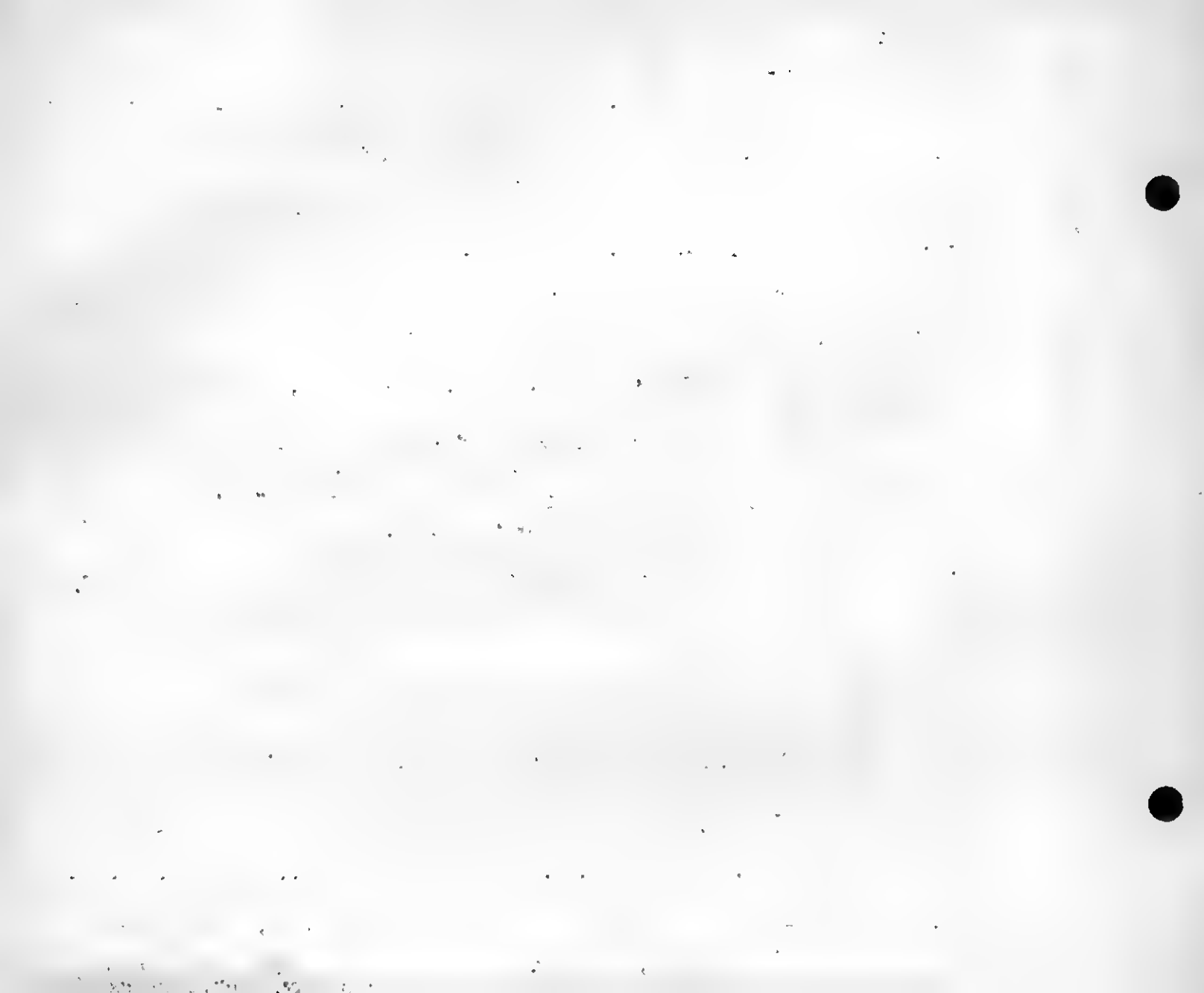
| | | | | | | | | | | | | | |
|---|--|---------------------|--|---|--|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME (Type or Print) George E Reid, III | | | | | | | | | | 2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8-5-68 | | 2b HOUR 194:55am | |
| 3 SEX Male | | 4 RACE White | | 5 DATE OF BIRTH 4-28-1949 | | 6 AGE (in years last birthday) 19 20 YRS | | 7c DATE PRONOUNCED DEAD Month 8 Day 5 Year 68 | | 2d HOUR 194:55am | | | |
| 7a BIRTHPLACE (State or foreign country) Md | | | | 7b CITIZEN OF WHAT COUNTRY? U S A | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 COUNTY OF DEATH Prince George's | |
| 10 CITY OR TOWN OF DEATH Riverdale | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial Hospital | | | | 12a I.S.A. OCCUPATION (Kind of work done during most of workable, even if retired) Clerk | | | | 12b KIND OF BUSINESS OR INDUSTRY Restaurant | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b COUNTY Prince George's | | | | 13c CITY OR TOWN College Park | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 5013 Cherokee Street | |
| 14 FATHER'S NAME First Middle Last George E. Reid Jr | | | | | | 15 MOTHER'S MAIDEN NAME First Middle Last Elizabeth Long | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | | 16b SOCIAL SECURITY NO 213 56 6350 | | | | 17 INFORMANT L. Reid ADDRESS Elizabeth Reid College Park, Md. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral hemothorax DUE TO, OR AS A CONSEQUENCE OF Fracture of ribs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1234 | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b TIME OF INJURY Month, Day, Year 12:45am 8-5- 19 68 | | | | 21c HOW INJURY OCCURRED (Enter nature of injury) struck a telephone pole. Passenger of car which went out of control and | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 3700 block Fairland Road, Beltsville, Maryland | | | | 21f LOCATION Street or RFD No City or Town County State Prince George Co. | | | | | |
| 22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | | | EXAMINER'S NAME (Type) John Kehoe MD | | | | 22b DATE SIGNED 8-6-68 | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b DATE Aug 8, 1968 | | | | 23c NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | | | | |
| 24 FUNERAL DIRECTOR F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | | | 25a RECD BY REGISTRAR DATE AUG 8 1968 | | | | | |
| | | | | | | | | 25b REGISTRAR'S SIGNATURE Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the lower papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|--|--|--|--|--|-----------------------------------|--|
| 12009 Items 7a & 7b CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Charles E. Riley | | | | | | August 2, 1968 | | 12:33 P | |
| 3 SEX | | 4 RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Male | | Caucasian | | August 22, 1903 | | 64 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CIT. ZEN. OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md | |
| Virginia | | USA | | | | Prince George's | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | | Prince Geo. Gen'l Hospital | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased administered) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13e. STREET AND NUMBER | |
| Maryland | | | Prince George's | | | Hillside | | 5237 Marlboro Pike, #304 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Charles E. Riley | | | Mary Fewell | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO | | | 17 INFORMANT | | | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> | | | 579 34 7002 | | | Tehra L. Riley, wife, Same As # 13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY. | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Acute generalized peritonitis with right sub-hepatic abscess.</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>hepatic abscess.</u> | | | | | | | | | |
| (b) <u>Leakage of hemicholecystomy and anastomosis.</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF <u>Adenocarcinoma of the colon.</u> | | | | | | | | | |
| (c) <u>Adenocarcinoma of the colon.</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 1. <u>Coronary heart failure, (2) Old myocardial infarct. (3) Cerebral infarct.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 22 July | | Intestinal obstruction | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18) | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (I) <u>Thomas M. Hutchins</u> attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>Aug. 2</u> , 19 <u>68</u> , that (I) <u>was</u> last saw the deceased alive on <u>August 2</u> , 19 <u>68</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>was</u> (did) <u>not</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| <u>Thomas M. Hutchins</u> | | 8-2-68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Thomas M. Hutchins, M. D. | | 7315 Landover Rd., Landover, Maryland | | | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 8-6-68 | | Cedar Hill Cemetery | | Suitland, Prince Georges, Md | | | |
| 24. FUNERAL DIRECTOR Robert E. Wilhelm | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| 4308 Suitland Road, Suitland, Maryland | | | | DATE AUG 8 1968 | | <u>Charles Judge</u> | | | |



CERTIFICATE OF DEATH

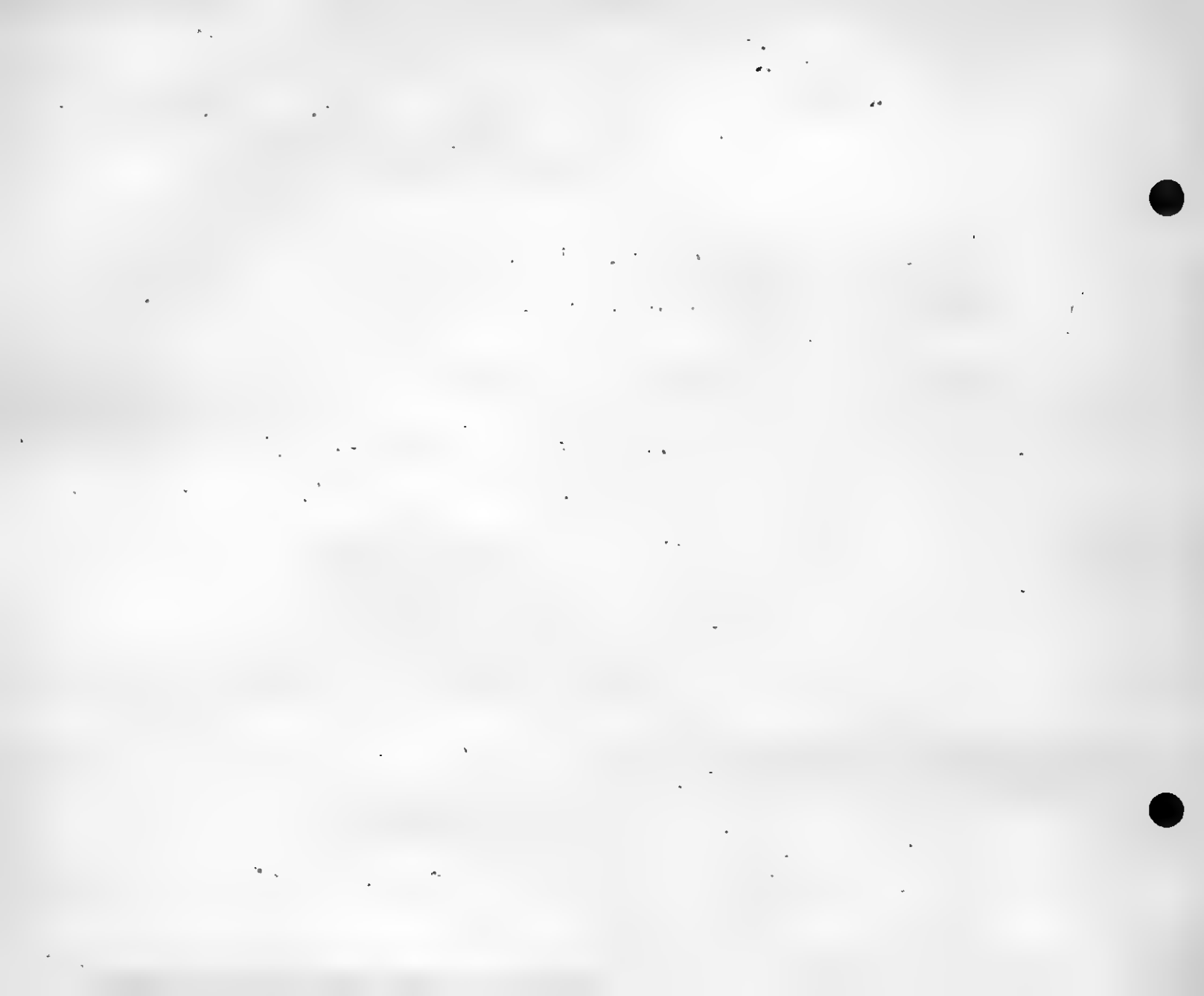
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| | | | | | | | | | |
|--|--|---|---|--|--|---|--|--|--|
| 1 DECEASED-NAME (Type or print) First Middle Last Donald L. Riley | | | 2a. DATE OF DEATH Month Day Year Aug. 29, 1968 | | | 2b. HOUR 8:31P.M. | | | |
| 3 SEX male | | 4 RACE white | | 5. DATE OF BIRTH Sept. 9 1912 | | 6 AGE (In years last birthday) 55 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Kansas | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH DOA Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA Prince Geo. Gen'l Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) U.S. Government | | 12b. KIND OF BUSINESS OR INDUSTRY D.G.O. | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Prince George's College Park | | 13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET AND NUMBER 85 Edmonston Rd. | | 14. FATHER'S NAME First Middle Last Danial A. Riley | | 15 MOTHER'S MAIDEN NAME First Middle Last Clerine Belle Isle | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO 217-30-0733 | | 17 INFORMANT Mrs. D.L. Riley | | Address 8500 Edmonston Ave. Bryn Mawr, Md. | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) 2 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4-5-1 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | |
| 21g. State | | | | | | | | | |
| 22a. I certify that (I) (the physician) attended the deceased from 2/11 , 19 66 , to 8/29 , 19 68 , that (I) (the physician) last saw the deceased alive on 3/15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (saw) view the body after death | | | | | | | | | |
| 22b. SIGNATURE H. S. Brennan MD | | DEGREE | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 8/30/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) H. S. Brennan | | 22e. ADDRESS Cherry Chase md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 9/3/68 | | 23c. NAME OF CEMETERY OR CREMATORY East Lincoln | | 23d. LOCATION (City or Town) (County) (State) Washington D.C. | | | |
| 24 FUNERAL DIRECTOR Hilton Funeral Home | | ADDRESS Barnesville Md | | 25a. REC'D BY REGISTRAR SEP 4 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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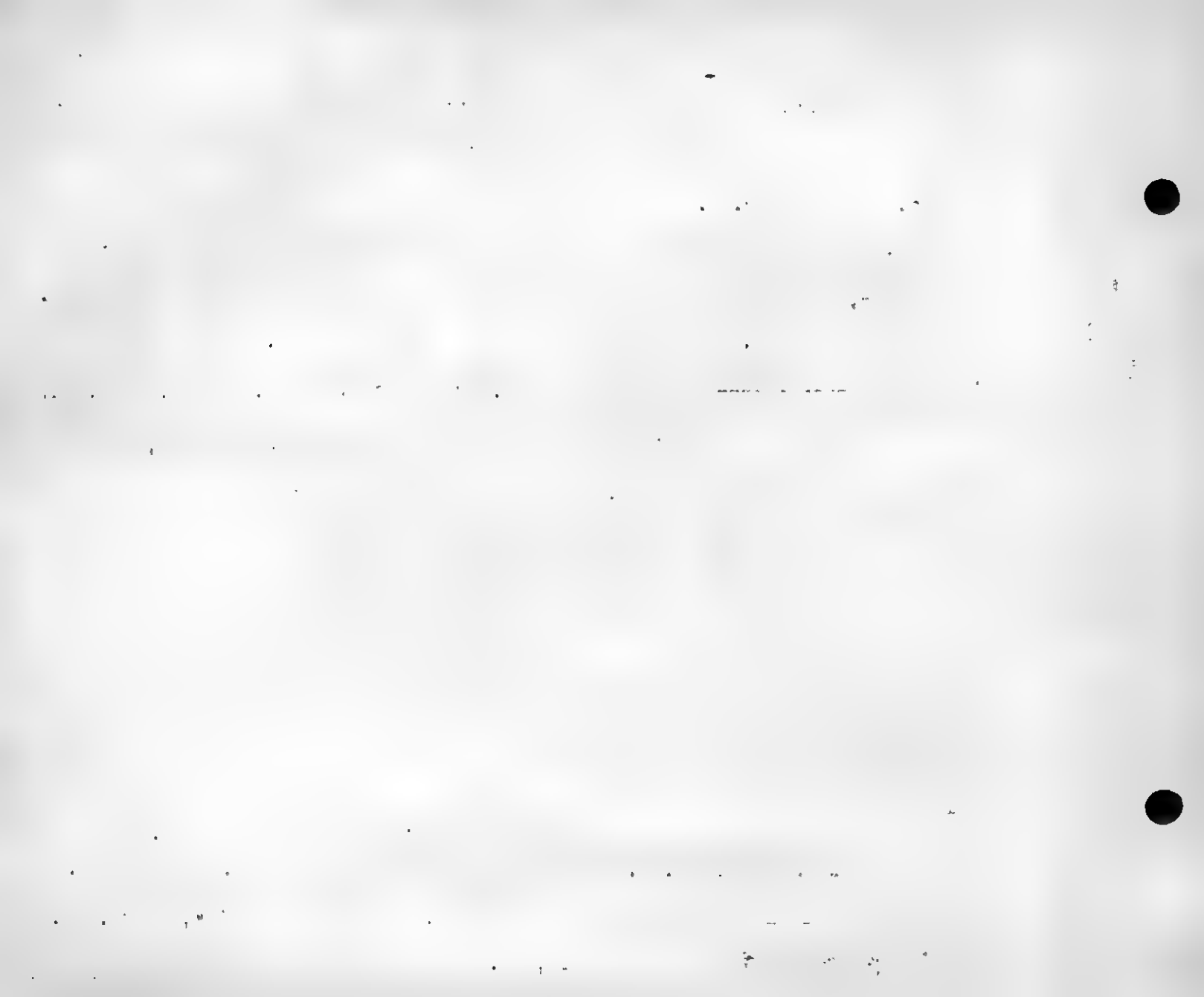
Medical Examiner notified and approved



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|------------------------------------|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 12011 CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Geraldine Elaine Roberts | | | | | | 2a. DATE OF DEATH Month Day Year 8 16 68 | | | 2b. HOUR 10 20 A.M. | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 9/26/25 | | 6. AGE (In years last birthday) 42 YRS | | IF UNDER 1 YEAR MONTHS DAYS 0 0 | | IF UNDER 24 HRS. HOURS MIN. 0 0 | |
| 7a. BIRTH-PLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Laurel | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Laurel General Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Homemakers | | | 12b. KIND OF BUSINESS OR INDUSTRY None | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Prince George | | 13c. CITY OR TOWN Laurel | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 6304 Brooklyn Bridge Rd. | | |
| 14. FATHER'S NAME First Middle Last Joseph M. Goodhart | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Edith M. Geiser | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No | | | | 16b. SOCIAL SECURITY NO. 19-11 | | 17. INFORMANT Address Mrs. Hazel Geiser 23 W. 3rd St. Fred. Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Fibroadipose tissue with metastatic, anaplastic, 19-11 DUE TO, OR AS A CONSEQUENCE OF (b) poorly differentiated adenocarcinoma DUE TO, OR AS A CONSEQUENCE OF (c) last Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 19-12 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE J. M. Warren M.D. | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22c. DATE SIGNED 8/16/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) J. M. Warren, M. D. | | | | 22e. ADDRESS 305 Prince George St., Laurel, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 8-19-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Resthaven Memorial Gardens | | 23d. LOCATED ON (City or Town) (County) (State) Frederick, Fred. Md. | | | | | |
| 24. FUNERAL DIRECTOR Robert E. Dailley & Son | | | | ADDRESS Frederick, Md. | | 25a. REC'D BY REGISTRAR DATE AUG 20 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |



12012

CERTIFICATE OF DEATH

020

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY PRINCE GEORGE MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHEVERLY | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) E. RIVERDALE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) PRINCE GEORGE GENERAL HOSPITAL | | d. STREET ADDRESS 6123 Kenilworth Avenue | |
| 3. NAME OF DECEASED (Type or print) ARCHIE First ROSENBLATT Last | | 4. DATE OF DEATH Month August Day 21 Year 1968 | |
| 5. SEX Male | 6. COLOR OR RACE W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10-17-03 |
| 9. AGE (In years) 64 yrs | | 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT | | 10b. KIND OF BUSINESS OR INDUSTRY LIQUOR STORE | |
| 11. BIRTHPLACE (County & State, or foreign country) WASHINGTON DC | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME NATHAN ROSENBLATT | | 14. MOTHER'S MAIDEN NAME ANNIE WASSERMAN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT WIFE | | Address Henrietta B. Rosenblatt (Same as #2) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary artery disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 4201 (b) Ch. Congestive failure (c) 1 year. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus - | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from May 5, 1939 , to 8-21, 1968 , that (I) (we) last saw the deceased alive on 8-21, 1968 , and that death occurred at 6:20 P.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE George Hageage | | 22b. DATE SIGNED 8-21-68 | |
| 22c. PHYSICIAN'S NAME (Type) GEORGE HAGEAGE | | 22d. ADDRESS 3718 38th AVE. COTTAGE CITY, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 8-23-68 | 23c. NAME OF CEMETERY OR CREMATORY CHEV SHOLOM - TALMUD TORAH CEM. WASHINGTON - D.C. | |
| 24. FUNERAL DIRECTOR BERNARD DANZANSKY SONS. WASH. D.C. | | 25a. REC'D. BY REGISTRAR AUG 26 1968 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12013 CERTIFICATE OF DEATH | | | | | | | | | | | |
|---|--|-------------------------------------|---|--|--|--|--|---|---|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Marion CAROL Ross | | | 2a. DATE OF DEATH Month Day Year Aug 18 1968 | | | 2b. HOUR 2:45 PM | | | | | |
| 3. SEX FEMALE | | 4. RACE CAUC. | | 5. DATE OF BIRTH 10/13/1895 | | 6. AGE (in years last birthday) 72 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH PRINCE GEORGES MD | | | | | |
| 10. CITY OR TOWN OF DEATH FORESTVILLE | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Regent Nursing Home BEAULIEU | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PERSONAL TOLOGY | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE New Jersey | | | 13b. COUNTY - | | 13c. CITY OR TOWN ATLANTIC CITY | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 157 S. NEW YORK AVE | | |
| 14. FATHER'S NAME First Middle Last ESIDORE LEVY | | | 15. MOTHER'S MAIDEN NAME First Middle Last MARTHA BLOOMSBURG | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | | 16b. SOCIAL SECURITY NO 145-209901 | | 17. INFORMANT EDWARD ROSS | | | Address 7447 RED STONE LANE FORESTVILLE MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis of left hemi- DUE TO, OR AS A CONSEQUENCE OF Diabetic mellitus plegia Conditions, if any, which gave rise to immediate cause (b) DUE TO, OR AS A CONSEQUENCE OF stating the underlying cause lost (c) ASHD | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY) OFFICE BUILDING, ETC | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-23, 1968, to 8-18, 1968, that (I) (we) last saw the deceased alive on 8-18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE John F. Shay | | | DEGREE JOHN F. SHAY | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED 8-18-68 | | |
| 22d. PHYSICIAN'S NAME (Type) JOHN F. SHAY | | | 22e. ADDRESS Suitland, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 8-20-68 | | 23c. NAME OF CEMETERY OR CREMATORY HAR NEBO CEM | | 23d. LOCATION (City or Town) (County) (State) FARMERSVILLE MD PA | | | | |
| 24. FUNERAL DIRECTOR Goldberg Funeral Home 4217 9th | | | ADDRESS | | | 25a. REC'D BY REGISTRAR JAN Wackoe | | 25b. REGISTRAR'S SIGNATURE 257 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MIDDLE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--------------------|--|--|--|--|---|---|--|--|---|--|
| 12014 CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Isiah - Roy | | | | | | 2a. DATE OF DEATH Month Day Year 8 - 13 - 68 | | | 2b. HOUR 10:10A | | | |
| 3 SEX M | | 4 RACE N | | 5. DATE OF BIRTH 5/9/1899 | | | 6. AGE (In years lost birthday) 69 YRS. | | IF UNDER MONTHS | | IF UNDER 24 MRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Va. | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Prince Georges. Md | | | |
| 10. CITY OR TOWN OF DEATH Glenn Dale | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Glenn Dale Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) retired | | | 12b. KIND OF BUSINESS OR INDUSTRY unknown | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Washington, D.C. | | | | 13b. COUNTY D.C. | | 13c. CITY OR TOWN Washington, D.C. | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 920 O St., N. W. | | |
| 14. FATHER'S NAME First Middle Last Barney Roy | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Frances William | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown unknown | | | | 16b. SOCIAL SECURITY NO. 225-20-3362 | | 17. INFORMANT decedent | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate with generalized metastases DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 177X | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Decubitus ulcers, heels and sacral region | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 11/25 , 19 66 , to 8/13/ , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/13/ 1968 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Moe Weiss | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 8/13/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Moe Weiss, M.D. | | | | | | 22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 8-16-68 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Mem. Park | | | 23d. LOCATION (City or Town) (County) (State) Landover Pr. Geo. Md. | | | | |
| 24. FUNERAL DIRECTOR J. H. Hacylon | | | | | | ADDRESS 909 6th St N.W. | | 25a. REC'D BY REGISTRAR AUG 16 1968 | | 25b. REGISTRAR'S SIGNATURE Charles J. Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | |
|--|--|--------|------------------------------|--|------------------------------------|---|---------------------------------|---|---|---|------------------|--|--|--|
| Item 28 Film 404 9-5-68 ans MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12015 CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | |
| JAMES FRANKLIN SAGER | | | | | | AUG Month 21 Day 1968 | | | 5:45 M | | | | | |
| 3. SEX | | 4 RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| MALE | | CAUC | | 12 Jul 37 | | | 31 YRS. | | MONTHS | | DAYS | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | | |
| Virginia | | | U.S.A. | | | | | | PRINCE GEORGES | | | Md. | | |
| 10. CITY OR TOWN OF DEATH | | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| ANDREWS AFB | | | | MALCOLM GROW USAFH | | | | RETIRED | | | | AF | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before) | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| VIRGINIA | | | | WINCHESTER | | | | | | 1015 KINZEL DRIVE | | | | |
| 14 FATHER'S NAME First Middle Last | | | | 15 MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | |
| MELVIN L. SAGER | | | | ANNA G. SHOWALTER | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT | | Address | | | | | | |
| YES | | | | 1959-1965 | | Wife | | Same as item # 13 | | | | | | |
| 18. CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1 DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Respiratory arrest or cardiac arrest</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| 18c. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | | | | | |
| (b) <u>Renal failure</u> | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | |
| (c) <u>Embryonal cell carcinoma of testicle</u> | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 178 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 22d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFF CE. BUILDING, ETC) | | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| 22a. I certify that (X) (this subject) attended the deceased from <u>27 Jun</u> , 19 <u>68</u> , to <u>21 Aug</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>21 Aug</u> , 19 <u>68</u> , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <i>Allen D. Ward</i> | | | | | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED <u>21 Aug 68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) ALLEN D. WARD, CAPT USAF MC | | | | | | | | 22e. ADDRESS MALCOLM GROW USAF HSP ANDREWS AFB | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| BURIAL | | | 8-23-68 | | MT. HEBRON | | | | WINCHESTER, FREDERICK | | V.A. | | | |
| 24 FUNERAL DIRECTOR <i>James H. Fleming</i> | | | | ADDRESS WINCHESTER, VA. | | | | 25a. REC'D BY REGISTRAR DATE <u>AUG 26 1968</u> | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i> | | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 5A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

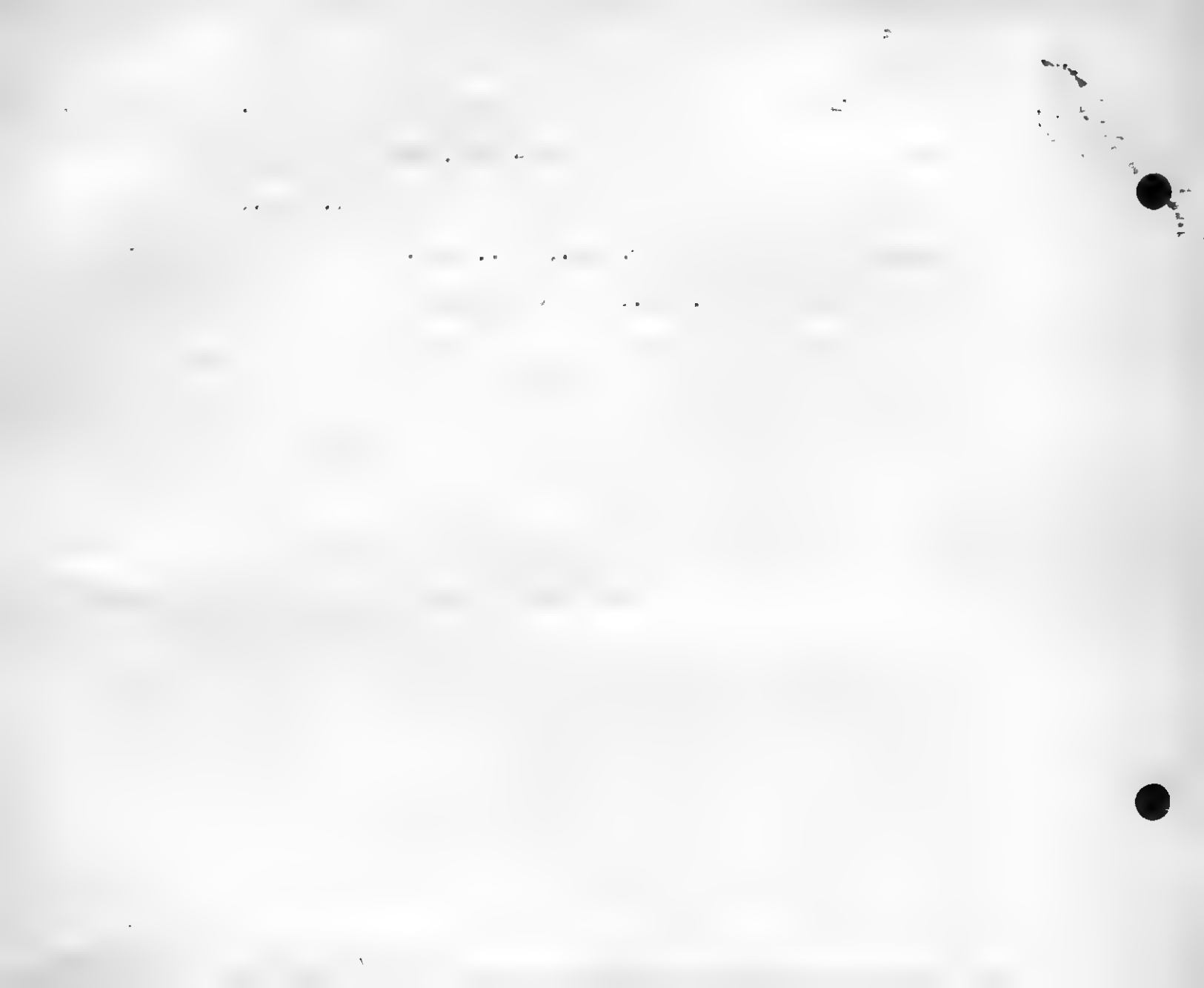
VR A15 15
30M REV 1/58

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|
| 12017 CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) First Middle Last SAMUEL SHACKLEFORD | | | 2a. DATE OF DEATH Month Day Year 8 17 68 | | | 2b. HOUR 10:30 | | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH 8-5-1895 | | 6. AGE (In years last birthday) 73 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY? AMERICAN | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH PRINCE GEORGES Md. | | | |
| 10. CITY OR TOWN OF DEATH CLINTON | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PINEVIEW NURSING HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY PRINCE GEORGES | | 13c. CITY OR TOWN CLINTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 7506 DANGERFIELD RD | |
| 14. FATHER'S NAME First Middle Last THOMPSON SHACKLEFORD | | | 15. MOTHER'S MAIDEN NAME First Middle Last ? | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) UNKNOWN | | 16b. SOCIAL SECURITY NO. 579-36-5364 | | 17. INFORMANT PINEVIEW NURSING HOME | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause just 2007 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN 10 MIN | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Metastatic Malignancy Directed Pleura - Source unknown | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED None | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, specify medical examiner) None | | 21b. TIME OF INJURY Hour A.M. P.M. Month Day Year None | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) None | | | | | |
| 21d. INJURY OCCURRED Where? (If in place of work, specify) None | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) None | | 21f. LOCATION Street or R.F.D. No. City or Town County State None | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from SEPT. 19 58 to PRESENT , that (we) last saw the deceased alive on 8/15 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Arthur Shaver, MD | | 22c. DATE SIGNED 8/19/68 | | 22d. PHYSICIAN'S NAME (Type) ARTHUR SHAVER JR MD | | 22e. ADDRESS 8808 BRANCH AVE, CLINTON, MD | | | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial | | 23b. DATE Aug. 20, 68 | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Gardens | | 23d. LOCATION (City or Town) (County) (State) Clinton, Maryland | | | |
| 24. FUNERAL DIRECTOR James R. Bost | | ADDRESS 101-104 Hope Rd. SE. DC | | 25a. REC'D BY REGISTRAR DATE AUG 20 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

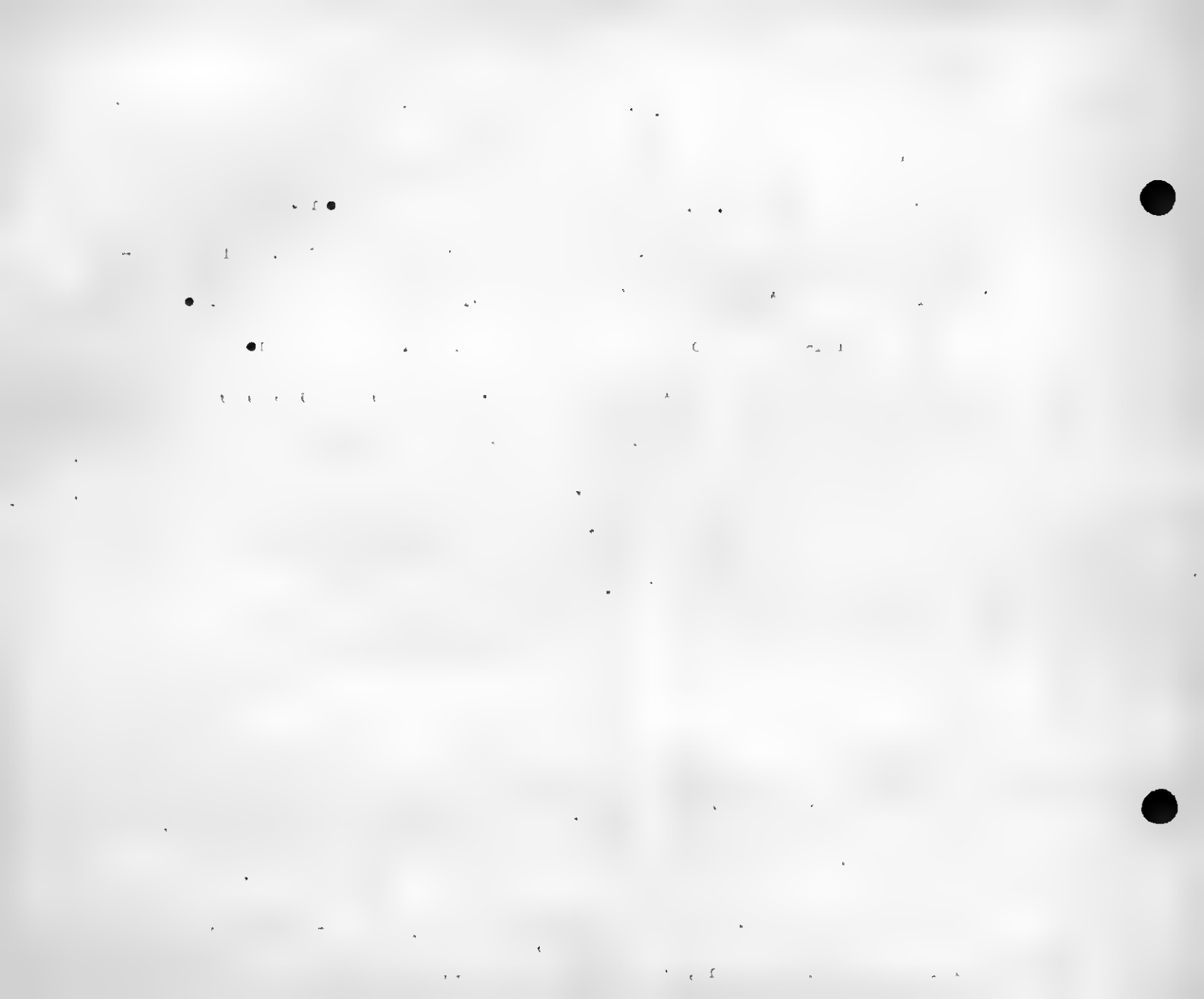
| | | | | | | | | | | | |
|--|--|---|--|--|---|---|---|--|---|--------------------------------|--|
| <div style="text-align: center;"> <div>12018</div> <div>MARYLAND STATE DEPT. OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> </div> | | | | | | | | | | | |
| <div style="display: flex; justify-content: space-between;"> <div>Item #5, Film G403 8/16/68 km</div> <div>CERTIFICATE OF DEATH</div> <div>12018</div> </div> | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) First Middle Last Frank CSCAR Shreve | | | | | | 2a. DATE OF DEATH Month Day Year Aug., 7 1968 | | | 2b. HOUR 3:50AM | | |
| 3 SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 4 Dec. 1891 1889 | | 6 AGE (In years last birthday) 78 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) VA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Pr. Geo., Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo., Gen., Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) MAINTENANCE MAN | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | 13b. COUNTY Pr. Geo., | | 13c. CITY OR TOWN Seat Pleasant | | 13d. INSIDE CITY LIM. TST YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 610 62nd Place | | |
| 14. FATHER'S NAME First Middle Last Unknozn | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Unknozn | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) Yes | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address Minnie L Shreve 610 62nd Pl. Seat Pleasant Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Carcinoma of Prostate with metastases | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis of coronary heart disease | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | | |
| 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC | | | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 1, 1964 to Aug 7, 1968 , that (I) (we) last saw the deceased alive on Aug 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death | | | | | | | | | | | |
| 22b. SIGNATURE William Brainin DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. DATE SIGNED 7/7/68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) William BRAININ 22e. ADDRESS 6056 Central Ave, Capitol Heights | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | Aug 10 1968 | | FT MINNEN | | | | BLADENSBURG | | MD | |
| 24. FUNERAL DIRECTOR ROBERT E WILHELM ADDRESS 43-8 SUTHLAND RD. SUTHLAND MD. | | | | | | | | | | | |
| 25a. REC'D BY REGISTRAR AUG 12 1968 | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Form 5 per telephone order with funeral home 8/28/68 kk 1027 | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED NAME (Type or print) PETER | | | First Middle Last M. SKIADOS | | | 2a. DATE OF DEATH Month Day Year Aug. 24, 1968 | | | 2b. HOUR 3:45 A.M. | | |
| 3 SEX male | | | 4 RACE white | | | 5 DATE OF BIRTH 1888 15 August 1888 | | | 6 AGE (In years last birthday) 80 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) Greece | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Montgomery Pr. George's Md. | | |
| 10. CITY OR TOWN OF DEATH Hyattsville | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Madison Manor Nursing Home | | | 12a. USUA. OCCUPAT ON (Kind of work done during most of working life, even if retired.) ret. sales | | | 12b. KIND OF BUSINESS OR INDUSTRY --- | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Hyattsville | | | 13d. INSIDE CITY LIM TSP YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 13e. STREET AND NUMBER 3366 Toled Terrace | | | 14. FATHER'S NAME First Middle Last Menelaus Skiados | | | 15. MOTHER'S MAIDEN NAME First Middle Last Callirohe Stavrianopoulos | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. unknown | | | 17. INFORMANT Address Mrs. Skiados, 13 a, b, c, d, e above | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (c) Cerebral arteriosclerosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day 1 Day years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 11, 1968 to 8-24, 1968 , that (I) (we) last saw the deceased alive on 8-23, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Donald C. Edgren M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 8-24-68 | | |
| 22d. PHYSICIAN'S NAME (Type) DONALD C. EDGREN | | | | | | 22e. ADDRESS 3500 East-West Highway Hyattsville, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 26 Aug. 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Washington, DC | | |
| 24. FUNERAL DIRECTOR Rinaldi Funeral Home Inc, 7400 Georgia Ave. | | | | | | ADDRESS NW, DC 2 - 242 RECD AT REGISTRATION AUG 27 1968 | | | DEATH REGISTRY SIGNATURE Judge | | |



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

16
1

20

| <div style="display: flex; justify-content: space-between;"> <div> <div style="background-color: black; color: white; padding: 2px 5px; font-weight: bold;">12020</div> <div>Item 13 taken from</div> </div> <div style="text-align: center;"> <div style="border: 1px solid black; padding: 2px; font-weight: bold;">CERTIFICATE OF DEATH</div> <div>State of Maryland</div> </div> <div style="text-align: right;"> <div style="border: 1px solid black; padding: 2px; font-weight: bold;">020</div> </div> </div> | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|---|--|
| 1. DECEASED-NAME <small>(Type or print)</small> <div style="display: flex; justify-content: space-between;"> First Baby Middle Girl Last Smith </div> | | | | 2a. DATE OF DEATH <div style="display: flex; justify-content: space-between;"> Month August Day 5 Year 1968 </div> | | | | 2b. HOUR <div style="display: flex; justify-content: space-between;"> 8 A. M. </div> | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH August 5, 1968 | | 6. AGE (In years last birthday) <div style="display: flex; justify-content: space-between;"> YRS. MONTHS DAYS </div> | | IF UNDER 1 YEAR <div style="display: flex; justify-content: space-between;"> MONTHS DAYS </div> | | IF UNDER 24 HRS. <div style="display: flex; justify-content: space-between;"> HOURS MIN. </div> | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's | | | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George's General | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland | | | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Forest Heights | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 323 Ottawa Street | |
| 14. FATHER'S NAME <div style="display: flex; justify-content: space-between;"> First Calvin Lee Smith Middle Last </div> | | | | 15. MOTHER'S MAIDEN NAME <div style="display: flex; justify-content: space-between;"> First Patricia Ann Pierce Middle Last </div> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT Mother | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> IMMEDIATE CAUSE (a) Multiple congenital anomalies with situs in- versus. </div> <div style="width: 70%;"> 7549 Multiple congenital anomalies with situs in- versus. </div> </div> | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21a. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/5 , 19 68 , to 8/5 , 19 68 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 8/5 , 19 68 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Pablo D. Falo | | | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED Aug. 8, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Pablo D. Falo, M. D. | | | | | | 22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 8/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY Prince George's Gen. Hospital | | | | 23d. LOCATION (City or Town) (County) (State) Cheverly, Md. | | | |
| 24. FUNERAL DIRECTOR HARRY W. PENN, JR., | | | | | | ADDRESS ADMINISTRATOR | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in (The funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Part 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12021 CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|---|--|--|--|---|--|
| 1 DECEASED NAME (Type or print) bhn W. Snoddy | | | 2a. DATE OF DEATH Month AUG. Day 28 Year 1968 | | | 2b. HOUR 530 P.M. | | | |
| 3 SEX M | | 4. RACE W | | 5. DATE OF BIRTH Oct. 19, 1880 | | 6. AGE (In years last birthday) 87 8/8 YRS. | | IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Tenn. | | 7b. CITIZEN OF WHAT COUNTRY? U S | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince Georges Md. | | | |
| 10 CITY OR TOWN OF DEATH Greenbelt | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Greenbelt Convalescent Center, Greenbelt | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD | | 13b. COUNTY Prince Georges | | 13c. CITY OR TOWN Riverdale | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 6621 Auburn Ave. | |
| 14 FATHER'S NAME First Middle Last Robert Newton Snoddy | | | 15. MOTHER'S MAIDEN NAME First Middle Last Susan Shields | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO | | 17 INFORMANT Address Thomas N Snoddy College Park, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR INSUFF. 4517 DUE TO, OR AS A CONSEQUENCE OF GEN. ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. UNKNOWN (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 MOS. | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CONGESTIVE HEART FAILURE | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 10-11 , 19 51 , to 8-26 , 19 68 , that (I) (we) last saw the deceased alive on 20 AUGUST 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE C. J. Houmann | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 26 AUG 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) C. J. HOUMANN | | 22e. ADDRESS RIVERDALE MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY Witts Foundry Cemetery | | 23d. LOCATION (City or Town) (County) (State) Witt Hamblen, Tennessee | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR AUG 29 1968 | | 25b. REGISTRAR'S SIGNATURE Charles J. ... | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12022 CERTIFICATE OF DEATH

1968

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) Eugene | | | First Middle Last | | | 2a. DATE OF DEATH Month Aug. Day 4 Year 1968 | | | 2b. HOUR 3,40AM | | |
| 3. SEX Male | | | 4. RACE Negro | | | 5. DATE OF BIRTH 18 April 1888 | | | 6. AGE (in years last birthday) 80 YRS | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Pr. Geo., Md | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Tramcar Fireman | | | 12b. KIND OF BUSINESS OR INDUSTRY DC Govt | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland | | | 13b. COUNTY Pr. Geo., | | | 13c. CITY OR TOWN Glendale | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME Arthur Snowden | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME Maria Williams | | | First Middle Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO. 220-03-1733 | | | 17. INFORMANT Elizabeth Johnson | | | Address Same as 3 E | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BLADDER 188X DUE TO, OR AS A CONSEQUENCE OF (b) Anemia DUE TO, OR AS A CONSEQUENCE OF (c) Acute fibrillation & asphyxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 188X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (x) (this hospital) attended the deceased from June 3, 1968 , to August 4, 1968 , that (x) (we) last saw the deceased alive on August 4, 1968 , and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (x) (we) (did) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Iradj Sadeghian | | | | | | DEGREE M. D. | | | 22c. DATE SIGNED August 5, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type) Iradj Sadeghian, M. D. | | | | | | 22e. ADDRESS Prince George's General Hospital, Cheverly | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE 8-9-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Holy Family | | | 23d. LOCATION (City or Town) (County) State Woodmore Md | | |
| 24. FUNERAL DIRECTOR H.S. Washington & Son | | | | | | ADDRESS 4925 Dean | | | 25. REC'D BY REGISTRAR DATE AUG 12 1968 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

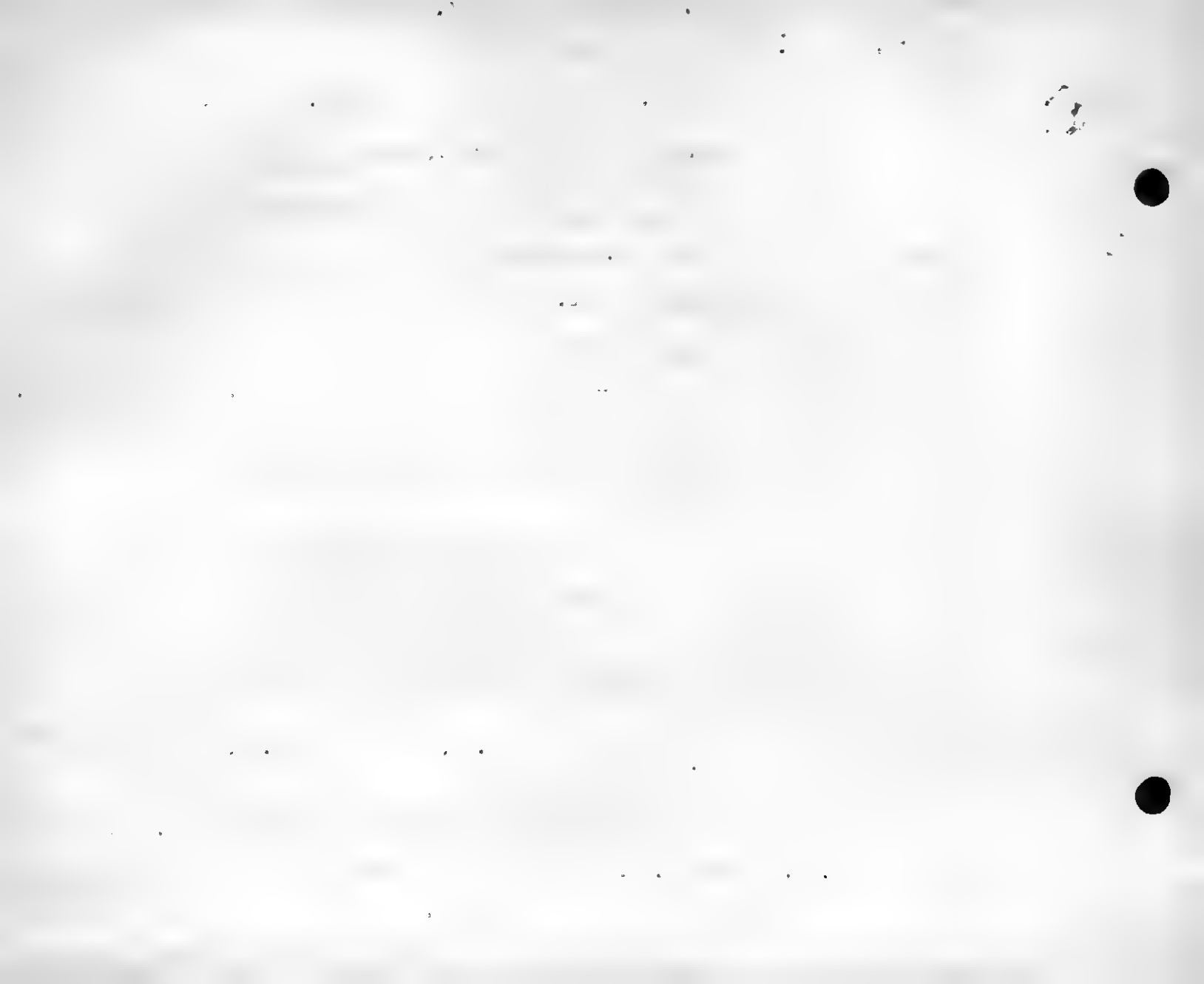
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|--|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 12023 CERTIFICATE OF DEATH 231 | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR P | |
| Baby Boy Snyder | | | | | | August 6, 1968 | | 12:10 | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH July 24, 1968 | | 6. AGE (in years last birthday) YRS. | | IF UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's | | Md. | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Prince George's | | 13c. CITY OR TOWN Lanham | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 5638 Whitefield Chapel Rd. | |
| 14. FATHER'S NAME First Middle Last Thomas Crelly | | | 15. MOTHER'S MAIDEN NAME First Middle Last Ann Elizabeth Snyder | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Partial intestinal obstruction - segmental gangrene of the large bowel. DUE TO, OR AS A CONSEQUENCE OF (b) Prematurity. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1b.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that we (this hospital) attended the deceased from <u>July 24, 1968</u> to <u>Aug. 6, 1968</u> , that we (we) last saw the deceased alive on <u>Aug. 6, 1968</u> , and that in our (our) opinion death occurred on the date and hour and from the causes stated above we (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Bernardo Alvarado</i> | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED Aug. 9, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D. | | | | 22e. ADDRESS Prince George's General Hospital, Cheverly | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 8/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY Prince Geo. General Hosp. | | 23d. LOCATION (City or Town) (County) Cheverly, Maryland Maryland | | | |
| 24. FUNERAL DIRECTOR HARRY W. PENN, JR., ADMINISTRATOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE AUG 20 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|
| 12024 CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last Charles P. Starkey | | | 2a. DATE OF DEATH Month Aug. Day 29 Year 1968 | | 2b. HOUR 6:25PM | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH June 6, 1893 | | 6. AGE (In years last birthday) 75 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign country) M.D.A. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's | | Md | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Painter | | 12b. KIND OF BUSINESS OR INDUSTRY - | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Prince George's Mt. Rainier | | 13c. CITY OR TOWN 4100 Russell Avenue | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last Peter Snyder | | | 15. MOTHER'S MAIDEN NAME First Middle Last Eva Snyder | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes | | 16b. SOCIAL SECURITY NO 579-11-2885 | | 17. INFORMANT Mrs. Perry Martin - 7d. Mt. Rainier, Md. | | Address 2901 - Russell | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PULMONARY EMBOLISM. DUE TO, OR AS A CONSEQUENCE OF (b) Varicella (chicken pox) - legs - R. H. H. H. DUE TO, OR AS A CONSEQUENCE OF (c) - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 463X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | | | | | |
| 22a. I certify that he (this hospital) attended the deceased from Aug. 8, 1968 to Aug. 29, 1968 , that he (we) last saw the deceased alive on Aug. 29, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) (did) not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE P. C. Xavier, M. D. | | | | DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> | | 22c. DATE SIGNED Aug. 30, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) P. C. Xavier, M. D. | | | | 22e. ADDRESS Prince George's General Hospital, Cheverly, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 9/2/68 | | 23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat. Cem. | | 23d. LOCATION (City or Town) (County) Baltimore, Md. | | | |
| 24. FUNERAL DIRECTOR Valley's Funeral Home Inc. | | | | ADDRESS 2200 - 7th St. | | 25a. REC'D BY REGISTRAR SEP 5 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



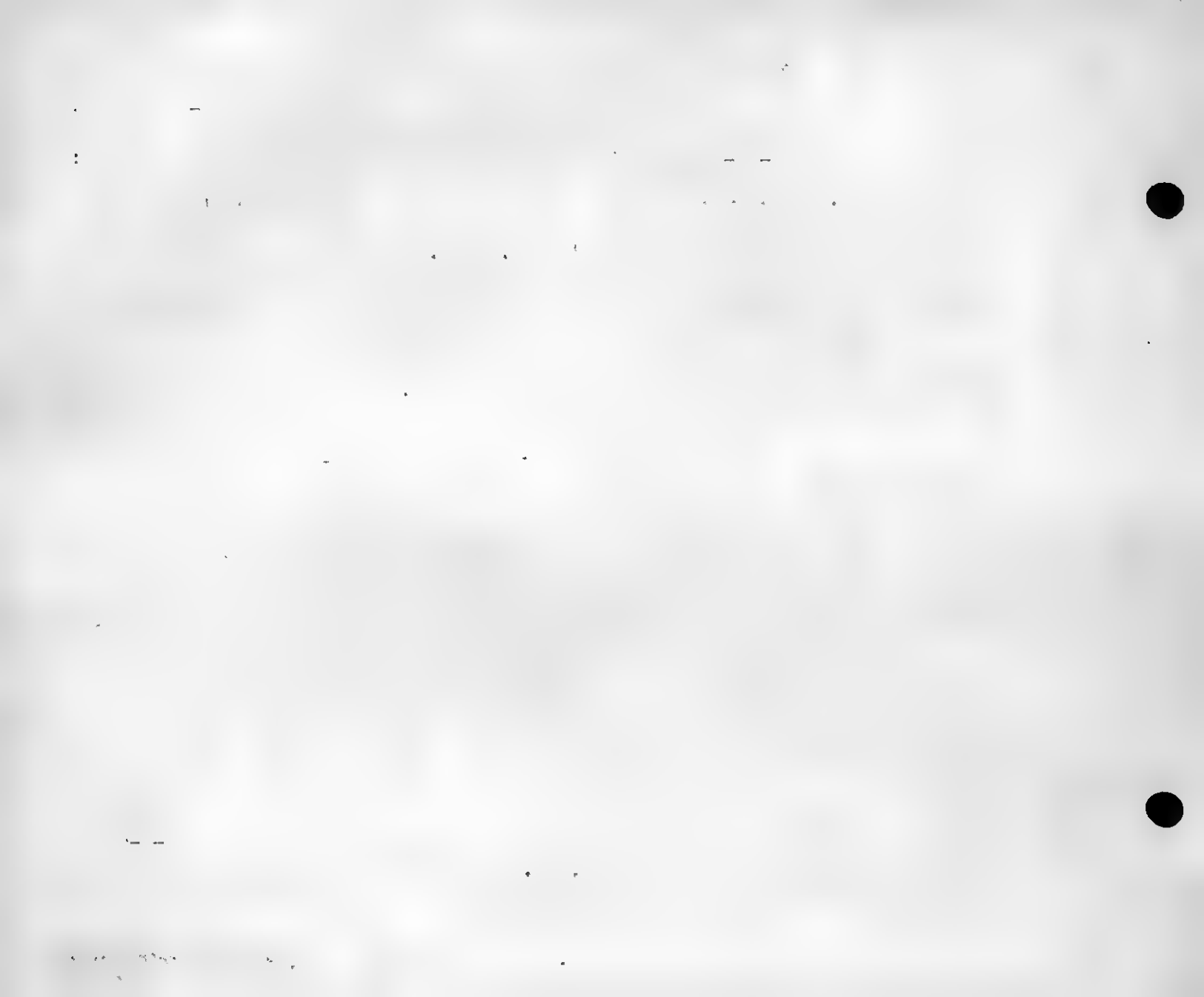
FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12023 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12023

| | | | | | | | | | | |
|---|--------|--|--------|---|---------------------------|---|--------------------------|-----------------------------------|------|--|
| 1 DECEASED NAME (Type or Print) | | First | Middle | Last | 2a DATE KNOWN OF DEATH | | Month | Day | Year | 2b. HOUR |
| Jean Elizabeth Teano | | | | | 8-5-68 | | 8 | 5 | 1968 | 1:30pm |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | | 6 AGE (in years last birthday) | IF UNDER 1 YEAR MONTHS | OAYS | IF UNDER 24 HRS HOURS | | MIN | 2c DATE PRONOUNCED DEAD |
| Female | White | 8-15-1928 | | 39 YRS | | | | | | Month 8 Day 5 Year 1968 |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Wash, D.C. | | U.S.A. | | | | Prince George's | | Md | | |
| 10. CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Cheverly | | Prince George's Gen. Hosp. | | | | Bank Clerk | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | Prince George's Parkway Estates | | | | | | 6612 Hillwood Drive | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| Charles W. Daiger | | | | | Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | | 17. INFORMANT | | ADDRESS | | | | |
| | | | | Eugene V. Teano | | Same as # 13 above | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | |
| (b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) _____ | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B) | | | | | | |
| | | HOUR A.M. P.M. 19 | | | | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State |
| | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | |
| EXAMINER'S NAME (Type) John Kehoe MD | | Riverdale, Md. | | | | 8-6-68 | | | | |
| 23a BURIAL CREMATION, REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) |
| Burial | | 8-9-1968 | | Cedar Hill | | Suitland | | Pr George | | Id |
| 24 FUNERAL DIRECTOR | | ADDRESS | | | | 25a REC'D BY REG STRAR | | 25b REGISTRAR'S SIGNATURE | | |
| Robert A. Mattingly | | 131 11th St S.E. Wash, DC | | | | DATE AUG 8 1968 | | Charles Judge | | |



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 10034 | |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 12026 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) Julitta Thompson | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> EST. <input checked="" type="checkbox"/> MATED <input checked="" type="checkbox"/> 8-13-68 | | 2b. HOUR 11:00am | | | |
| 3 SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH 28 Sept. 1951 | | 6. AGE (In years last birthday) 16 YRS. | | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | | IF UNDER 24 HRS HOURS _____ MIN _____ | |
| 7a. BIRTHPLACE (State or foreign country) North Carolina | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's | | Md | |
| 10. CITY OR TOWN OF DEATH Oxon Hill | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2507 Southern Ave. Apt. 303 | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE District of Columbia | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Washington | | 13d. USUAL CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER 1813 N. Capitol St., N.E. | |
| 14. FATHER'S NAME James Robinson | | | | | | 15. MOTHER'S MAIDEN NAME Flossie Thomas | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO | | 17. INFORMANT Mrs. Ruby Mae Robinson-grandmother | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Interstitial myocarditis | | | | | | | | | | days | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause | | | | | | | | | | | |
| (b) and pulmonary edema & congestion | | | | | | | | | | days | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) Pneumonia | | | | | | | | | | days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4211 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe MD | | EXAMINER'S NAME (Type) John Kehoe MD | | Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASS STANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| | | | | | | ADDRESS (Street, city, town, or county) | | 22b. DATE SIGNED 8-14-68 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park | | 23d. LOCATION (City or Town) Maryland | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR John T. Stewart Jr. | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE Charles Jones | | | |
| Stewart Funeral Home-4001 Benning Rd., N.E. DATE AUG 19 1968 | | | | | | | | | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | |
|---|------------------------|---|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or Print) Wayne Francis Thompson | | | 2a. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> DEATH MATED <input checked="" type="checkbox"/> 8-17-68 195: 15pm | | | 2b. HOUR 15pm | | |
| 3 SEX Male | 4 RACE Negro | 5 DATE OF BIRTH 10-7-1956 | 6 AGE (n years last birthday) 11 YRS | 7 UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | 8 IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | 2c. DATE PRONOUNCED DEAD Month 8 Day 18 Year 1968 | | 2d. HOUR 5:37pm |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life (Given, if listed)) None | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Prince George's | | 13c. CITY OR TOWN Glen Arden | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 8814 Glen Arden Parkway |
| 14. FATHER'S NAME First Middle Last John Thompson | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Almay Kenner | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT ADDRESS Father 8814 Glenarden Pkwy., Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Electrical shock 701X DUE TO, OR AS A CONSEQUENCE OF Struck by lightning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 5:15pm 8-17- 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Struck by lightning | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Livingroom of home | | 21f. LOCATION Street or R.F.D. No same as # 13 | | City or Town County State | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | EXAMINER'S NAME (Type) John Kehoe MD | | M.D. Riverdale, Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED 8-19-68 |
| ASS STANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8-22-68 | | 23c. NAME OF CEMETERY OR CREMATOR Harmony Park | | 23d. LOCATION (City or Town) (County) (State) Landonover Ind | | |
| 24. FUNERAL DIRECTOR Rollins 4339-Hunt PL. NE | | | | 25a. REC'D BY REG STRAR DATE AUG 21 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please make a carbon copy of pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 12028 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| C36 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Bessie Middle Mario Last Thorne | | | 2a. DATE OF DEATH Month Aug Day 14 Year 1968 | | 2b. HOUR 1:55A M | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH 17 Dec., 1901 | | 6. AGE (In years last birthday) 66 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Pr. Georges Md | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo., Gen. Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Pr. Geo., | | 13c. CITY OR TOWN Upper Marlboro | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER RFD Box 2790 | |
| 14. FATHER'S NAME First Gustav Middle Smith Last Smith | | | | 15. MOTHER'S MAIDEN NAME First Kate Middle Habig Last Habig (-Same as item) #130-13- | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO (If yes give war or dates of service) -- | | 17. INFORMANT Wallace Edwin Thorne- | | 17. ADDRESS (-Same as item) #130-13- | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF Chronic Pyelonephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pyelonephritis DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct , 19 64 , to Aug , 19 68 , that (I) (we) last saw the deceased alive on 8/13 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE A. Clark Holmes | | | | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 8/14/68 |
| 22d. PHYSICIAN'S NAME (Type) A. Clark Holmes, M.D. | | | | | 22e. ADDRESS Upper Marlboro, Md. 20870 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY Trinity Cemetery | | 23d. LOCATION (City or Town) (County) (State) Upper Marlboro, Pr. G., Md. | | | |
| 24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md. | | | | | 25a. REC'D BY REGISTRAR AUG 22 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers attached 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|---|--|--|--|--|--|--|
| 120222 CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED NAME (Type or print) First Middle Last <i>Almaude Tibbs</i> | | | 2a. DATE OF DEATH Month Day Year <i>8 17 68</i> | | | 2b. HOUR M <i>2:25</i> | | | |
| 3 SEX <i>Female</i> | | 4 RACE <i>NEGRO</i> | | 5. DATE OF BIRTH <i>AUG 28, 85</i> | | 6 AGE (In years last birthday) <i>82</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a BIRTHPLACE (State or foreign country) <i>Canada</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>PRINCE GEORGES</i> Mo. | | | |
| 10. CITY OR TOWN OF DEATH <i>FORESTVILLE</i> | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>REGENT NURSING HOME</i> | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Govt -</i> | | | |
| 13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <i>D.C.</i> | | 13b COUNTY <i>✓</i> | | 13c CITY OR TOWN <i>Washington</i> | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER <i>4708-13th St N.W.</i> | |
| 14 FATHER'S NAME First Middle Last <i>Samuel H. McKenny</i> | | | 15 MOTHER'S MAIDEN NAME First Middle Last <i>CHARINDA - Newton</i> | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) <i>None NO</i> | | 16b. SOCIAL SECURITY NO <i>220-05-5441A</i> | | 17 INFORMANT Address | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>COMA</i> <i>4337</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CEREBRAL INFARCTION (RIGHT)</i> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 1B) | | | | | |
| 21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e PLACE OF INJURY (At home farm, street, factory, office building etc) | | 21f LOCATION Street or RFD No City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3-18-1968</i> , to <i>8-17-1968</i> , that (I) (we) last saw the deceased alive on <i>8-13-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>Oliver B. Bond MD</i> | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED <i>8/17/68</i> | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>OLIVER. B. BOND</i> | | | | 22e ADDRESS <i>6872 RIVERDALE ROAD LANHAM MARYLAND 20801</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE <i>8-21-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Hormony Mem. Park</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Lanham, Md</i> | | | |
| 24 FUNERAL DIRECTOR <i>John T. Rhinier</i> | | | | ADDRESS <i>3415-12th St N.E. Washington D.C. 20018</i> | | 25a REC'D BY REGISTRAR DATE <i>AUG 22 1968</i> | | 25b REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
12030 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|--|------------------------|--|--|---|-------------------------------|---|--|---|--|--|--|--|--|
| 1 DECEASED NAME (Type or Print) Kathleen | | | First Middle Last Thurston | | | 2a DATE KNOWN OF DEATH EST MATED 8-17-68 | | | 2b HOUR 30am | | | | |
| 3 SEX Female | 4 RACE White | 5 DATE OF BIRTH 7-21-1918 | 6 AGE (in years last birthday) 50 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2c DATE PRONOUNCED DEAD Month 8 Day 17 Year 68 | | | 2d HOUR 6:02am | | | | |
| 7a BIRTHPLACE (State or foreign country) Mass. | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Prince George's Md. | | | | | | | |
| 10 CITY OR TOWN OF DEATH Cheverly | | | NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General Hosp. | | | 12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) Nurse Aide | | | 12b KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland | | | 13b COUNTY Prince George's | | | 13c CITY OR TOWN Suitland | | | 13d INS. DE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e STREET AND NUMBER 3962 Suitland Road | |
| 14 FATHER'S NAME Henry Mulhern | | | First Middle Last | | | 15 MOTHER'S MAIDEN NAME Catherine Shea | | | First Middle Last | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | | | 16b SOCIAL SECURITY NO 026-05-6046 | | | 17 INFORMANT Kathleen M. Thurston | | | ADDRESS 7910 Knollwood Dr. | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4107 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4 | | | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe MD | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 22b DATE SIGNED 8-18-68 | | | | |
| EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md. | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a BURIAL, CREMATION REMOVAL (Specify) Burial | | | 23b DATE Shipped 8-23-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Sawtell Natl. Cemetery | | | 23d LOCATION (City or Town) (County) (State) Los Angeles, Calif. | | | | |
| 24. FUNERAL DIRECTOR Wilhelm Funeral Home | | | | | | ADDRESS 4308 Suitland Rd. S.E. | | | 25a. REC'D BY REG STRAR AUG 27 1968 | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper tags 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|---|--|---------|--|------------------|--|--|---------------------------------|--|--|--|--|-----|--|
| 12031 CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | |
| Harry | | | Walter | | | Townshend, Sr. | | | Month Day Year 8 17 68 240 P M | | | | |
| 3 SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR | | 8. UNDER 24 HRS | | |
| Male | | White | | Jan. 15, 1892 | | | 7 YRS. | | MONTHS DAYS | | HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Maryland | | | U. S. A. | | | | | | Prince Georges | | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Mitchellville | | | Sunnyside Farm | | | Tobacco Farming | | | Own Farm | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. INSIDE CITY LIMITS? | | | 13d. STREET AND NUMBER | | | | |
| Md. | | | Pr. Geo's | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | Sunnyside Farm | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | | | |
| G.C.D. Townshend | | | Alice Walker | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | | | |
| No | | | 217-36-5934 | | | Ruth Kerna Townshend- Mitchellville, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Benign Prostatic Hyperplasia</u> | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Benign Prostatic Hyperplasia</u> | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC. | | | 21f. LOCATION | | | Street or R.F.D. No City or Town County State | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1, 1968</u> to <u>Aug. 1968</u> , that (I) (we) last saw the deceased alive on <u>8/17/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | | | |
| <u>A. Clark Holmes</u> | | | | | | | | | <u>8/17/68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | |
| A. Clark Holmes, M. D. | | | Upper Marlboro, Md. 20870 | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 8/20/68 | | | Mt. Oak Cemetery | | | Mitchellville, Pr. Geo Md | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Ritchie Bros. Upper Marlboro, Md. | | | | | | DATE AUG 22 1968 | | | <u>J. Charles Judge</u> | | | | |

STL-30-237

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 8 F-1-107 12/9/68 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|--------------------|---|---|--|-------------------------------------|--|-------------------------------------|---|--|
| 1. DECEASED-NAME (Type or Print) Edney | | Middle | | Last Van Pelt | | 2a. DATE KNOWN OF DEATH ESTIMATED Month <input checked="" type="checkbox"/> 8 Day 21 Year 1968 | | 2b. HOUR 9:40 p M | |
| 3 SEX M | 4 RACE W | 5 DATE OF BIRTH 28 Oct., 1913 | 6 AGE (in years last birthday) 54 YRS | IF UNDER 1 YEAR MONTHS 0 | IF UNDER 24 HRS DAYS 0 | IF UNDER 24 HRS HOURS 0 | IF UNDER 24 HRS MIN. 0 | 2c. DATE PRONOUNCED DEAD Month 8 Day 21 Year 1968 | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md. | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Prince George Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Painter | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | | | |
| 13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md. | | 13b. COUNTY Prince George Cheverly | | 13c. CITY OR TOWN YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 6206 Landover Rd. | | | |
| 14. FATHER'S NAME First Middle Last Edward Van Pelt | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Bessie B Bassford | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | 16b. SOCIAL SECURITY NO. W 7 11 | | 17. INFORMANT Stella M Van Pelt ADDRESS Cheverly, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contusion of brain stem and DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Right subdural hematoma DUE TO, OR AS A CONSEQUENCE OF (c) Trauma | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 705 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:30 AM 8 16 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell and struck head on parking lot. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) American Legion Hall | | 21f. LOCATION Street or R.F.D. No Colmar Manor | | City or Town P.G. | | State Md. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe | | EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED 8-22-68 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug 24, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery | | 23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md. | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons | | | | ADDRESS Hyattsville, Md. | | 25a. RECEIVED BY REGISTRAR AUG 26 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or inhumation, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|---|--|---|--|--|---|--|--|---|--------------------------------|--|
| 12033 | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Alexander | | | First Middle Last -- Wardrett | | | 2a. DATE OF DEATH Month Day Year 8 11 1968 | | | 2b. HOUR 9:35PM | | | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH 12/27/1917 | | | 6. AGE (In years last birthday) 50 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) N. C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince Georges Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH Glenn Dale | | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Glenn Dale Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) unemployed | | | 12b. KIND OF BUSINESS OR INDUSTRY -- | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Wash., D.C. | | | 13b. CITY OR TOWN Wash., D.C. | | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET AND NUMBER 1 1/2 P St., N. W. | | | | |
| 14. FATHER'S NAME First Middle Last Simon -- Wardrett | | | 15. MOTHER'S MAIDEN NAME First Middle Last Sally ---- Evans | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) no | | | 16b. SOCIAL SECURITY NO. 238-22-5971 | | | 17. INFORMANT Address Decedent | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral vascular accident, right | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week ? | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 337X | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Pulmonary tuberculosis, far advanced | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County State | | |
| 22a. I certify that (this hospital) attended the deceased from 7/23/1968 , to 8/11/1968 , that (we) last saw the deceased alive on 8/11/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (submit) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Max Weiss | | | DEGREE MD | | | ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22c. DATE SIGNED 8/11/1968 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Max Weiss, M. D. | | | 22e. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE 8-12-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Phasant Shade, Virginia | | | 23d. LOCATION (City or Town) (County) (State) Hampton, Va. | | | |
| 24. FUNERAL DIRECTOR Transfer to O.H. Smith & Son, Newport News, Va. JOHNSON & JENKINS FH 4804 G.A. AVE NW | | | | | | | | | | | | |
| RECD BY REGISTRAR DATE AUG 15 1968 | | | | | | 25b. REGISTRAR'S SIGNATURE John Charles Jones | | | | | | |

MEDICAL CERTIFICATION

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--------|-----------------------------|--|---|-------------------------------------|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a DATE KNOWN OF DEATH | | 2b HOUR | |
| Ernest Harvey Wartenberg- | | | | | | Month Day Year | | 196:00am | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS HOURS MIN | 2c DATE PRONOUNCED DEAD | | 2d HOUR | |
| Male | White | 6-17-1896 | 72 YRS | | | Month Day Year | | 14:25pm | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH | | | |
| New York City | | USA | | | | Prince George's Md | | | |
| 10 CITY OR TOWN OF DEATH | | | 11 NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| Cheverly | | | Prince George Gen. Hospital | | | Retired | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if not in institution, STATE) | | | 13b COUNTY | | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | Prince George's | | | Oxon Hill | | 3428 Brinkley Road | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Ernest P Wartenberg | | | Rose Coughlin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO | | | 17 INFORMANT ADDRESS | | | |
| Yes | | | 11 577 427 238 | | | Mary J Wartenberg Oxen Hill, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia | | | | | | | | | |
| 953X DUE TO, OR AS A CONSEQUENCE OF Hanging | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 974X | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | 6:00am 8-13- 19 68 | | | Hung self in basement. | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | Basement of 4901 41st. Place, Hyattsville, Prince George Co., Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | |
| EXAMINER'S NAME (Type) | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 8-14-68 | |
| John Kehoe MD | | | Riverdale, Md. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | |
| 23a. BURIAL (Cremation, Burial) (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR REPOSITORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | Aug 16, 1968 | | Arlington National | | Arlington Virginia | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REG STRAR | | 25b. REGISTRAR'S SIGNATURE | |
| F. Gasch's Sons | | | Hyattsville, Md. | | | DATE AUG 19 1968 | | Charles Judge | |

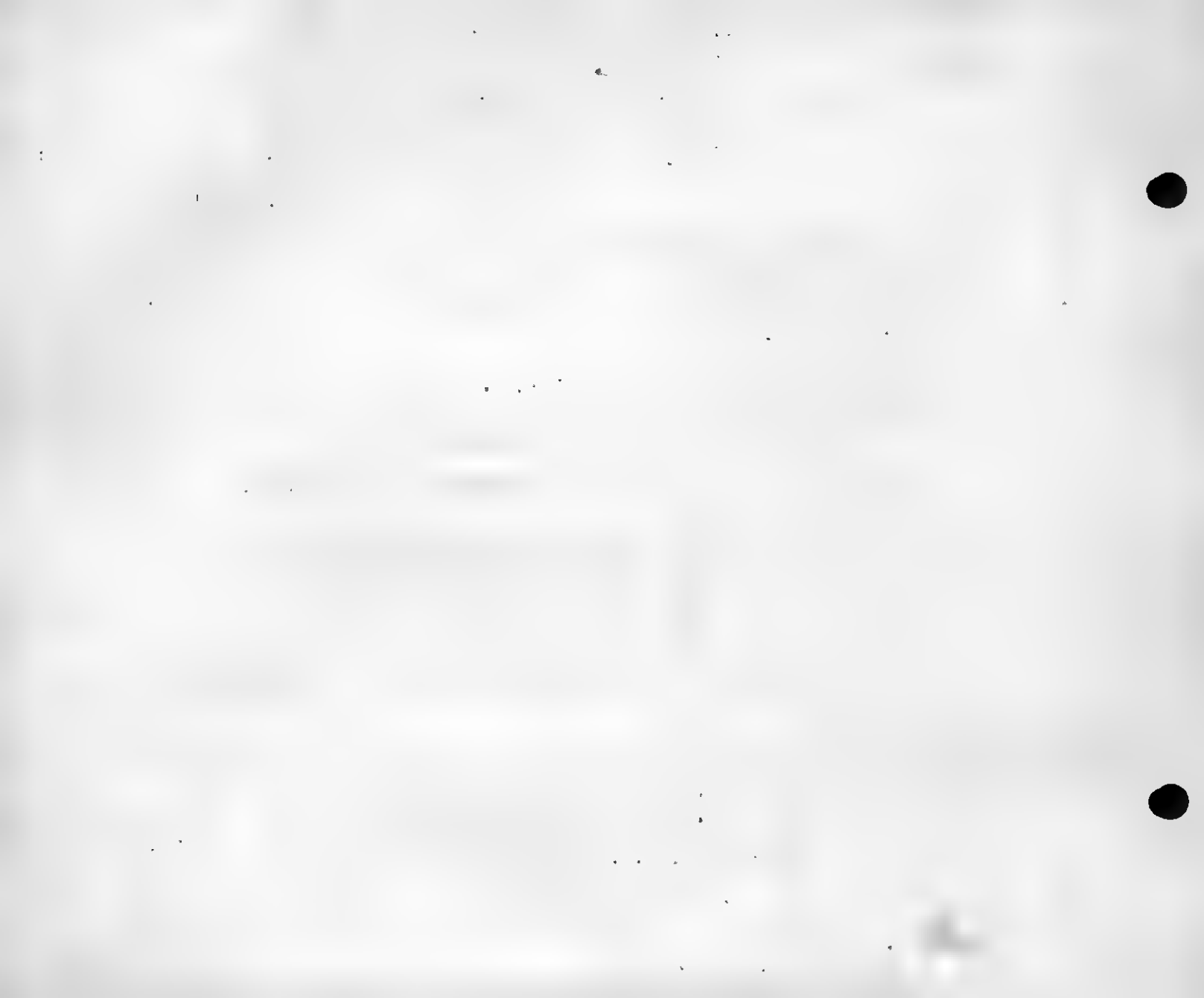


FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--------|---|--------------------------------|--|------|---|------|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12038 - 1212043 | | | | | | | | | | | |
| 1 DECEASED NAME (Type or Print) | | First | | Middle | | Last | | 2a DATE KNOWN OF DEATH | | 2b HOUR | |
| George | | Wiston | | Washington | | | | Month Day Year | | M | |
| 3 SEX | 4 RACE | 5 DATE OF BIRTH | 6 AGE (In years lost birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c DATE PRONOUNCED DEAD | | 2d HOUR | |
| Male | Negro | 2-12-1883 | 85 YRS. | MONTHS | DAYS | HOURS | MIN. | Month Day Year | | | |
| 7a BIRTHPLACE (State or foreign country) | | 7b CIT ZEN OF WHAT COUNTRY? | | 8a MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | | |
| F.A. | | U.S.A. | | WIDOWED | | DIVORCED | | Prince George's | | | |
| 10 CITY OR TOWN OF DEATH | | 11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) | | | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Cedar Heights | | 1007-65th AVE | | | | Retired U.S. Govt | | U.S. Govt | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE | | 13b COUNTY | | 13c CITY OR TOWN | | 13d INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Maryland | | Prince George Cedar Heights | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1007 65 th Ave. | | | |
| 4 FATHER'S NAME | | First | | Middle | | Last | | 15 MOTHER'S MAIDEN NAME | | First Middle Last | |
| Unknown | | | | | | | | Unknown | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b SOCIAL SECURITY NO | | 17. INFORMANT | | ADDRESS | | | | | |
| YES 1908-1911 | | | | Mrs. Henrietta Washington | | | | | | | |
| 8. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure | | | | | | | | | | Minutes | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| (b) Arteriosclerotic heart disease | | | | | | | | | | Unknown | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | | | | | | | |
| 4200 | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20 AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b TIME OF INJURY Month, Day, Year | | 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8) | | | | | | | |
| CAUSE OF DEATH | | HOUR A.M. P.M. | | 19 | | | | | | | |
| 21d INJURY OCCURRED | | 21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f LOCATION Street or R.F.D. No | | City or Town | | County | | State | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | John Kehoe | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b DATE SIGNED | |
| EXAMINER'S NAME (Type) | | John Kehoe, M.D., Riverdale | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) | | 8-26-68 | |
| 23a BURIAL CREMATION REMOVAL (Specify) | | 23b DATE | | 23c NAME OF CEMETERY OR CREMATORY | | 23d LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 8-29-68 | | Baltimore Nat Cem | | Catonsville | | | | Md. | |
| 24a PREPARED BY | | | | 25a REC'D BY REGISTRAR | | | | 25b REGISTRAR'S SIGNATURE | | | |
| S. Washington & Son, S | | | | DATE AUG 29 1968 | | | | James Judge | | | |
| 4925 Deane Ave NE. D.C. | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
304A REV 1-68

| MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|-----------------------------------|
| 1. DECEASED NAME (Type or print) | | First Pearl | | Middle Rose | | Last Weatherbee | | 2a. DATE OF DEATH Month 8 Day 9 Year 68 | | 2b. HOUR 1730M |
| 3. SEX Female | | 4. RACE Cau | | 5. DATE OF BIRTH 27 March 1899 | | 6. AGE (In years last birthday) 69 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Wash. D.C. | | 7b. CITIZEN OF WHAT COUNTRY? United States | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md. | | | | |
| 10. CITY OR TOWN OF DEATH Suitland | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Andrews AFB Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Prince George | | 13c. CITY OR TOWN Baltimore | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 2427 Iverson St. | | |
| 14. FATHER'S NAME First Middle Last William H. Dakin | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Catherine K. Hodges | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give year or dates of service) No | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Mrs P.R. Brown | | Address 2525 Corning Ave Oxon Hill Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure,</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHO.</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1705</u> | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>42</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>July 31, 1968</u> , to <u>Aug 9, 1968</u> , that (I) (we) last saw the deceased alive on <u>Aug 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>John F. Luedema</u> | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>8-9-68</u> |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | |
| 23a. BURIAL (CREMATION REMOVAL) (Specify) Burial | | 23b. DATE 8-12-68 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Suitland, Maryland | | | | |
| 24. FUNERAL DIRECTOR <u>Robert E. Williams</u> | | | | ADDRESS <u>41308 S. West and Rd. Suitland Md.</u> | | 25a. REC'D BY REG-STRAR DATE <u>AUG 16 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

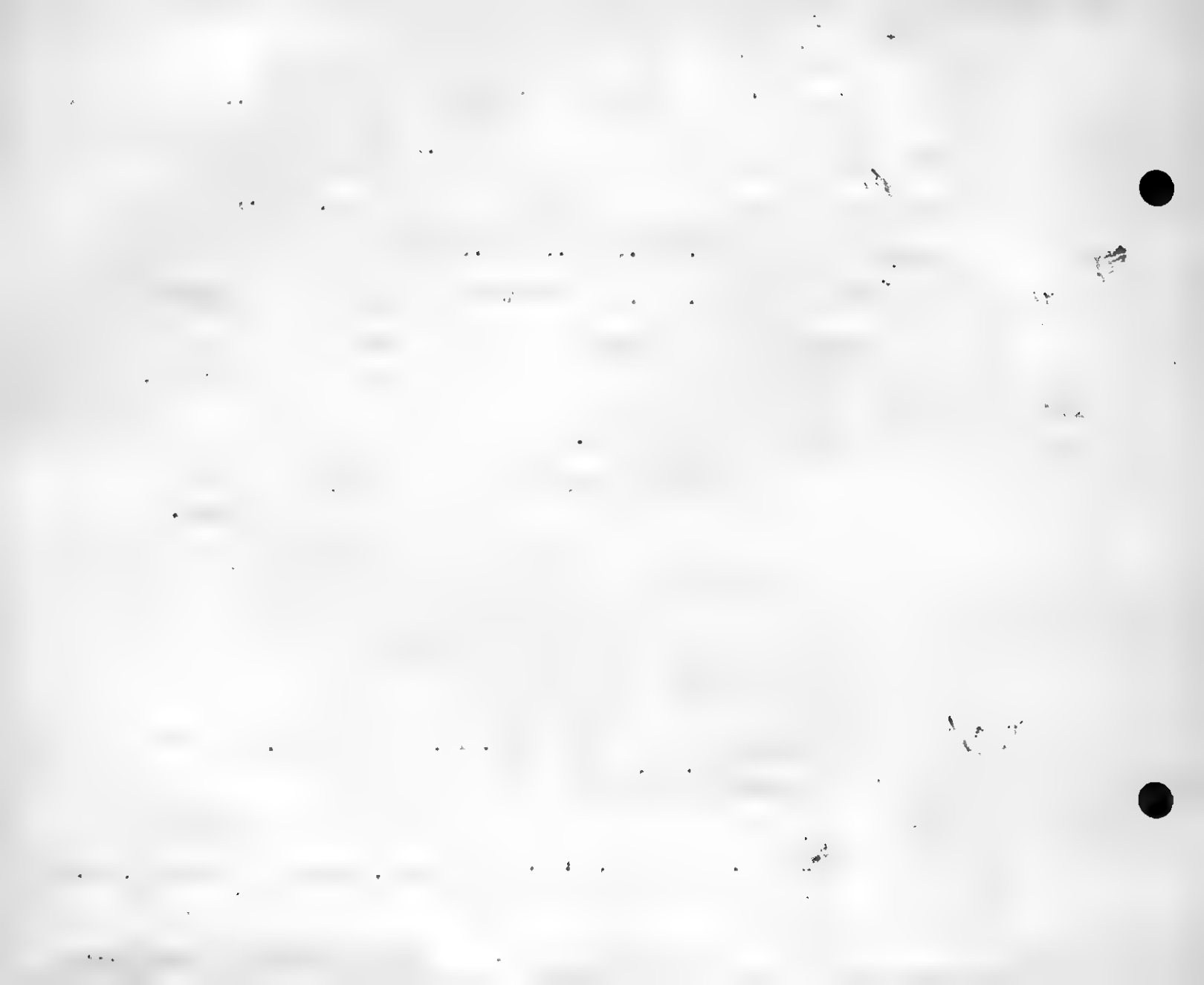
MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Model was kept

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|--|--|---|--|------------------------|--|---|
| 1. DECEASED NAME (Type or print) Baby Boy Weedon | | | | | 2a. DATE OF DEATH Month Aug. , Day 12 , Year 1968 | | 2b. HOUR 3,45AM | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH 11 Aug., 1968 | | 6. AGE (in years last birthday) — YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Pr., Geo., Md | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo., Gen., Hosp., | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | 13b. COUNTY Pr. Geo., | | 13c. CITY OR TOWN Greenbelt | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 36 B Ridge Road | |
| 14. FATHER'S NAME First Middle Last Andrew Weedon | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Sharon Capri | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) --- | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) ---- | | 17. INFORMANT Address Andrew Weedon Greenbelt, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Prematurity. 1120 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Hemorrhage with intraventricular hemorrhage. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH. |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 1615 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (his/her) attended the deceased from Aug. 11, 1968 to Aug. 12, 1968 , that (I) (we) last saw the deceased alive on Aug. 12, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (Type) William C. Weintraub, M. D. | | | | 22e. ADDRESS Prof Bldg. Centerway, Greenbelt, Md. 20770 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug 13, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Mt Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Washington D. C. | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md. | | | | 25a. REC'D BY REGISTRAR AUG 15 1968 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |



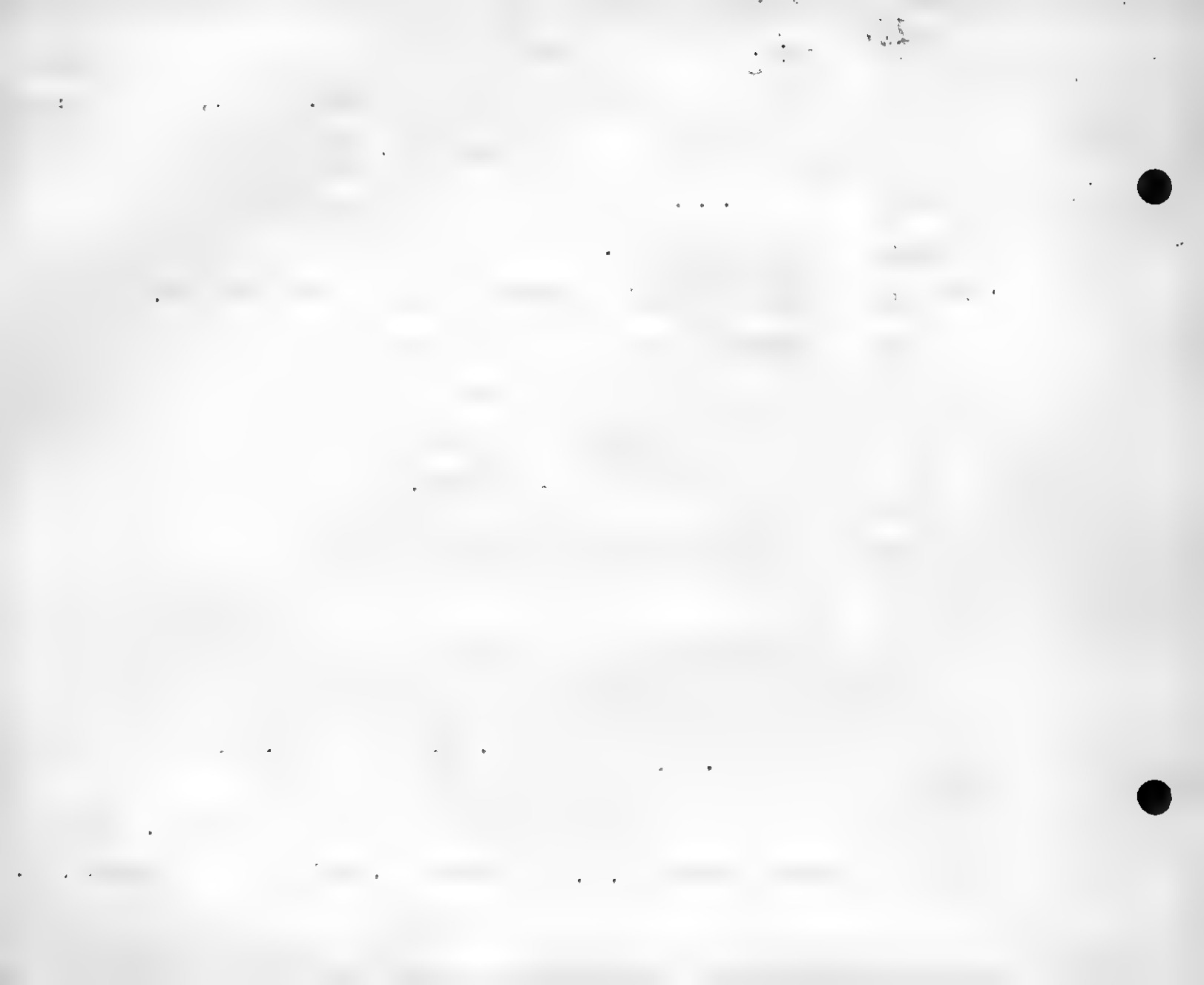
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

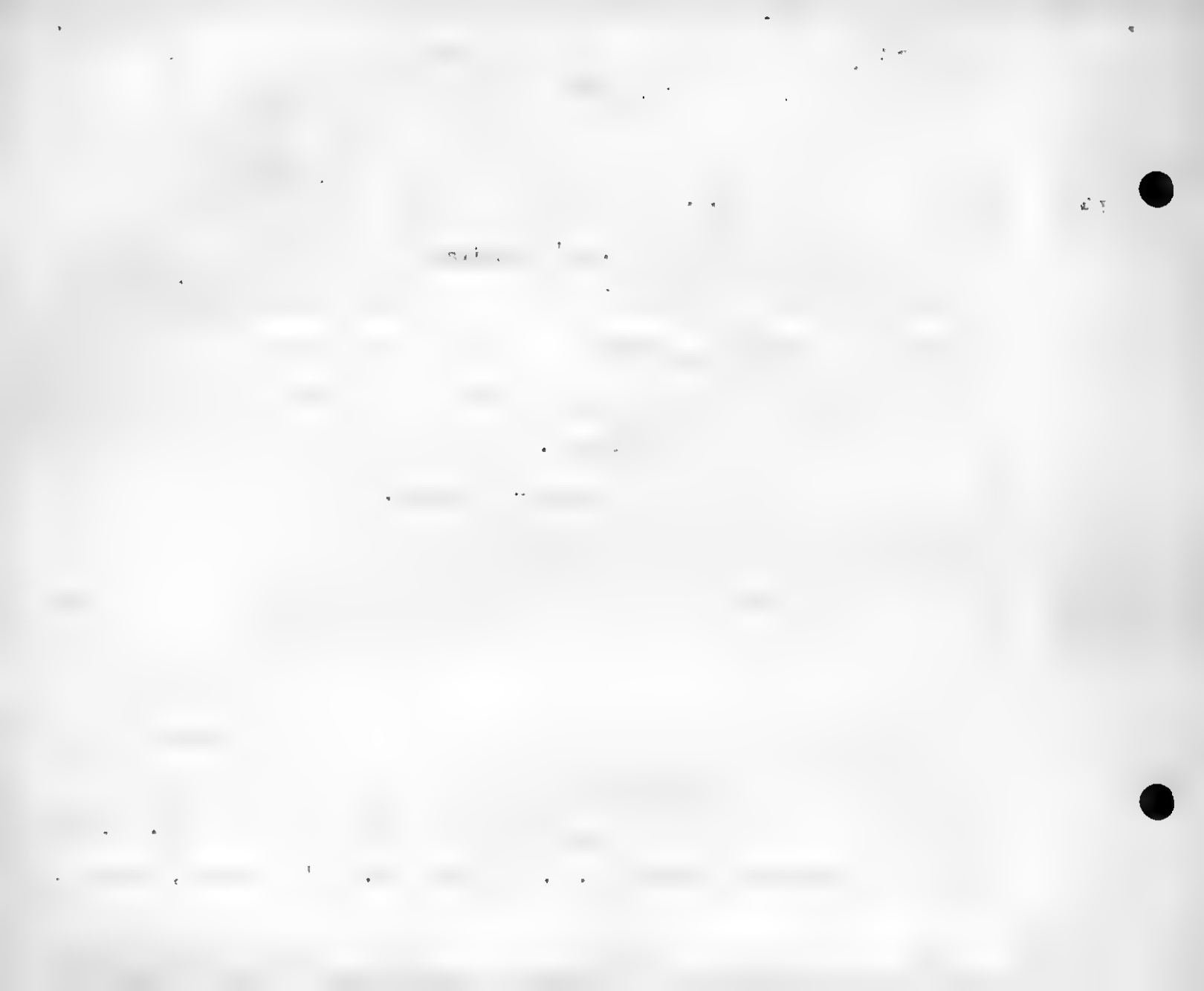
| | | | | |
|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) Baby Girl "A" Welch | | 2a. DATE OF DEATH Month Aug. Day 17 , Year 1968 | | 2b. HOUR 4:25 PM |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH August 16, 1968 | 6. AGE (In years lost birthday) YRS. 2 | IF UNDER 1 YEAR MONTHS 0 DAYS 0 |
| 7a. BIRTHPLACE (State or foreign country) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Prince George's Md. | |
| 10. CITY OR TOWN OF DEATH Cheverly | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE Maryland | 13b. COUNTY Prince George's | 13c. CITY OR TOWN Suitland | 13d. INSIDE CITY LIM. TS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 4719 Homer Ave. |
| 14. FATHER'S NAME First Thomas Middle Teddy Last Welch | 15. MOTHER'S MAIDEN NAME First Dicie Aline Middle Britton Last Britton | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Mother | | |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity DUE TO, OR AS A CONSEQUENCE OF (b) Atelectasis - bilateral. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County State |
| 22a. I certify that he (this hospital) attended the deceased from Aug. 16, 1968 , to Aug. 17, 1968 , that he (we) last saw the deceased alive on Aug. 17, 1968 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. he (we) did (did not) view the body after death. | | | | |
| 22b. SIGNATURE Bernardo Alvarado, M. D. | 22c. DATE SIGNED Aug. 19, 1968 | 22d. PHYSICIAN'S NAME (Type) Prince Geo. Gen'l Hospital, Cheverly, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE 8/31/68 | 23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital | 23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland | |
| 24. FUNERAL DIRECTOR HARRY M. PENTT JR. ADMINISTRATOR | 25a. REC'D BY REGISTRAR SEP 5 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|---|---|--|--|---|--|--|--|
| 120339 CERTIFICATE OF DEATH | | | | | | | | | |
| 1 DECEASED-NAME (Type or print) First Middle Last Baby Girl "B" Welch | | | 2a. DATE OF DEATH Month Day Year August 17, 1968 | | | 2b. HOUR 8:15AM | | | |
| 3 SEX Female | | 4 RACE White | | 5. DATE OF BIRTH August 16, 1968 | | 6 AGE (In years last birthday) YRS. MONTHS DAYS 12 19 | | IF UNDER 1 YEAR IF UNDER 24 HRS. | |
| 7a BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 COUNTY OF DEATH Prince George's Md | | | |
| 10 CITY OR TOWN OF DEATH Cheverly | | 11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital | | 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b KIND OF BUSINESS OR INDUSTRY | | | |
| 13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm. ssion) STAT Maryland | | 13b COUNTY Prince Geo. | | 13c CITY OR TOWN Suitland | | 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET AND NUMBER 4719 Homer Avenue | |
| 14. FATHER'S NAME First Middle Last Thomas Teddy Welch | | | 15. MOTHER'S MAIDEN NAME First Middle Last Dicie Aline Britton | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Mother Address | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atelectasis - bilateral.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a I certify that (this hospital) attended the deceased from <u>August 16</u> , 19 <u>68</u> , to <u>August 17</u> , 19 <u>68</u> , that (we) lost the deceased alive on <u>August 17</u> , 1968, and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <u>(I (we) did not view the body after death.)</u> | | | | | | | | | |
| 22b. SIGNATURE <i>[Signature]</i> | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED Aug. 19, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) Bernardo Alvarado, M. D. | | | | 22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 8/31/68 | | 23c. NAME OF CEMETERY OR CREMATORY Prince George's General Hospital | | 23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland | | | |
| 24 FUNERAL DIRECTOR HARRY W. PENN, JR., ADMINISTRATOR | | | | 25a REC'D BY REGISTRAR SEP 5 1968 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |



1
TO HOSPITAL. The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Prince George | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland | | b. COUNTY Prince George | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | c. LENGTH OF STAY IN 1b 21 months | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville | | d. STREET ADDRESS 610 Riggs Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 10 Riggs Road | | 4. DATE OF DEATH Month 8 Day 25 Year 1968 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) Mother Pia First Middle Last Margaret Woesner | | 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH June 24, 1880 | | 9. AGE (In years last birthday) 88 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teaching | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Germany | | 12. CITIZEN OF WHAT COUNTRY? Germany | |
| 13. FATHER'S NAME Albert Wiesner | | 14. MOTHER'S MAIDEN NAME Bertha Nader | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. 039-32-5967 | |
| 17. INFORMANT Agnes Desautels | | Address 6910 Riggs Road, Hyattsville, Md. | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4107 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO coronary occlusion arteriosclerotic heart disease | | INTERVAL BETWEEN ONSET AND DEATH 5 yrs. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 4201 None | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None | |
| 20c. TIME OF INJURY Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (1) (this hospital) attended the deceased from Aug. 26, 1968, to Aug. 26, 1968, the (1) (we) last saw the deceased alive on Aug. 26, 1968, and that death occurred at 8:00 AM from the causes and on the date stated above. | | 22a. SIGNATURE James R. Goodson M.D. | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type) James R. Goodson M.D. | |
| 22d. ADDRESS 1746 K ST N.W. Washington D.C. | | 23a. BURIAL, CREMATION, 23b. DATE THEREOF Burial 8-28-68 | | 23c. NAME OF CEMETERY OR CREMATOR Regina Cemetery | | 23d. LOCATION (City, town or county) (State) Hyattsville Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE Francis J. Collins 4748 Wisc. Ave N.W. | | 25a. RECD BY REGISTRAR AUG 30 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|---|--|--|--|--|--|---|--|--|---|--|--|-----------------------------------|--|--|---------------------------------|--|--|------------------|--|--|--------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) | | | First Eva | | | Middle Hurd | | | Last Willis | | | 2a. DATE OF DEATH Month 8 | | | Day 17 | | | Year 68 | | | 2b. HOUR 7:00 | | | M M | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH June 24-1878 | | | 6. AGE (In years last birthday) 90 | | | YRS | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS HOURS MIN | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Texas | | | 7b. CITIZEN OF WHAT COUNTRY? American | | | 8. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Prince George Md. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hattsville, Md. | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hattsville Nursing Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) SCHOOL TEACHER-RET. | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland | | | 13b. COUNTY Montgomery | | | 13c. CITY OR TOWN Sumner, Md. | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER 5704 Overlea Rd. | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Judson | | | Middle Hurd | | | Last MARY | | | 15. MOTHER'S MAIDEN NAME First MARY | | | Middle - | | | Last - | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown NO | | | (If yes give war or dates of service) NONE | | | 16b. SOCIAL SECURITY NO. - | | | 17. IN: OR MAN MR. T. Leland Willis, 5704 OVERLEA RD. SUMNER, MD. | | | Address | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> 4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC CARDIO-</u> 11-1 YEARS | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24-48 HRS 2-3 DAYS | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>CHRONIC HEMIA</u> <u>ARTERIOSCLEROSIS</u> <u>OBLITERANS</u> | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC) | | | 21f. LOCATION Street or R.F.D. No | | | City or Town | | | County | | | State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>DEC. 1967</u> , to <u>AUG. 17, 1968</u> , that (I) (we) last saw the deceased alive on <u>AUG. 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Alexander L. Matas, M.D.</u> | | | DEGREE | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | | 22c. DATE SIGNED 8-17-68 | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) ALEXANDER L. MATAS | | | 22e. ADDRESS 1222 1704 ROG ST. N.E. WASH, D.C. 20017 | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE Aug 20, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | | 23d. LOCATION (City or Town) WASHINGTON, D.C. | | | (County) | | | (State) | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR JOSEPH GAWIERSKI | | | | | | 25a. REC'D BY REGISTRAR DATE AUG 21 1968 | | | | | | 25b. REGISTRAR'S SIGNATURE Charles J. Jager | | | | | | | | | | | | | | |

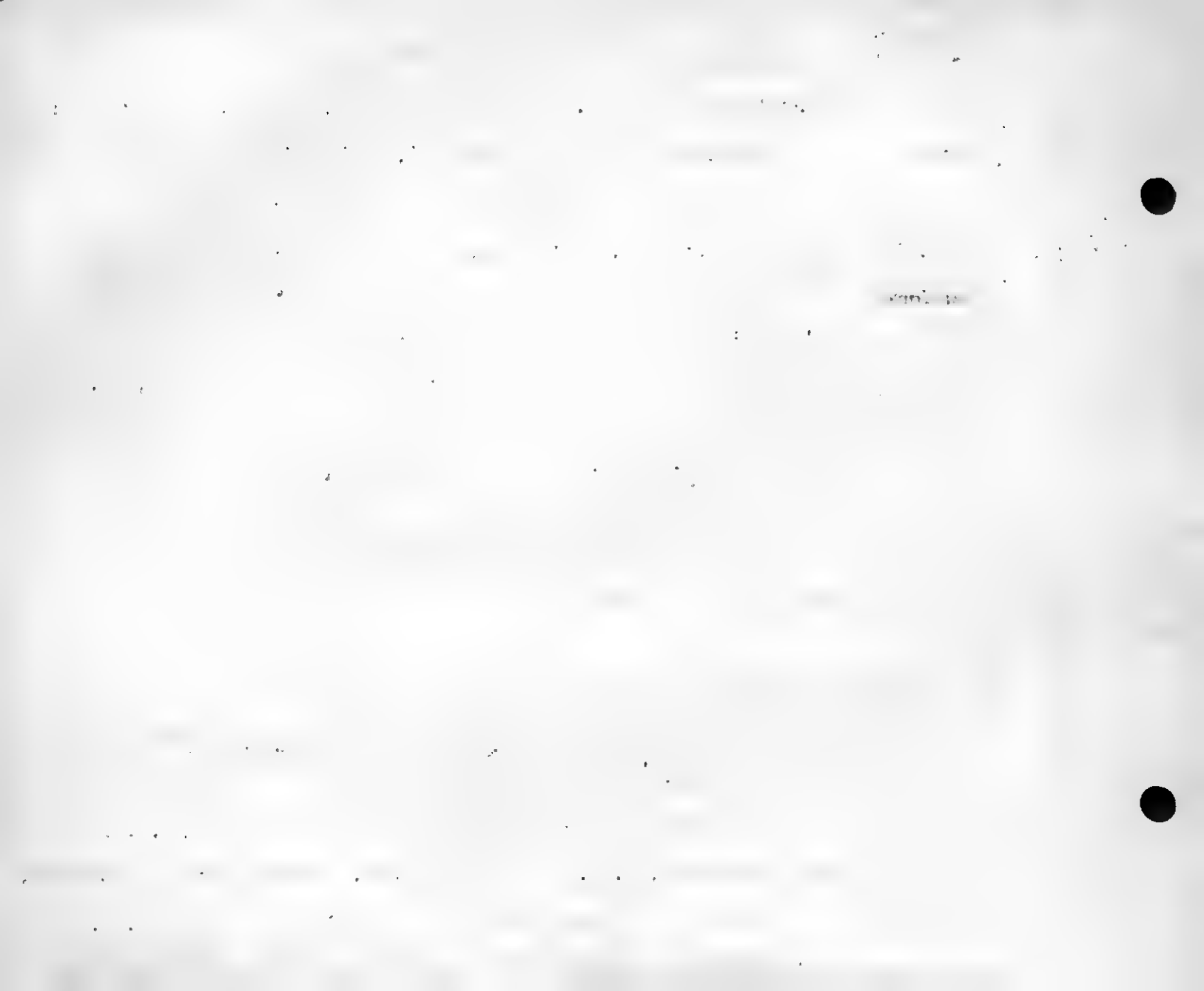
12042

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Florence M. Wilson | | | 2a. DATE OF DEATH Month August Day 19 Year 1968 | | | 2b. HOUR 4:40 PM | | | |
| 3 SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH March 24, 1893 | | 6. AGE (In years last birthday) 75 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) New York | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md. | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen'l Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) New York | | 13b. COUNTY Tioga | | 13c. CITY OR TOWN Waverly | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 72 Lincoln Street | |
| 14. FATHER'S NAME First Melvin Middle Emery Last | | | 15. MOTHER'S MAIDEN NAME First Nellie Middle Dewey Last | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Betty Nowark | | Address Hyattsville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF possible coronary embolization Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) None | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 16, 1968 , to August 19, 1968 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 19, 1968 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Iradi Sadeghian | | | | 22c. DATE SIGNED Aug. 20, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Iradi Sadeghian, M. D. | | | | 22e. ADDRESS Prince Geo. General Hospital, Cheverly, | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Aug 23, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Glenwood Cemetery | | 23d. LOCATION (City or Town) (County) Waverly Tioga N. Y. | | | |
| 24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md | | | | 25a. REC'D BY REGISTRAR DATE AUG 22 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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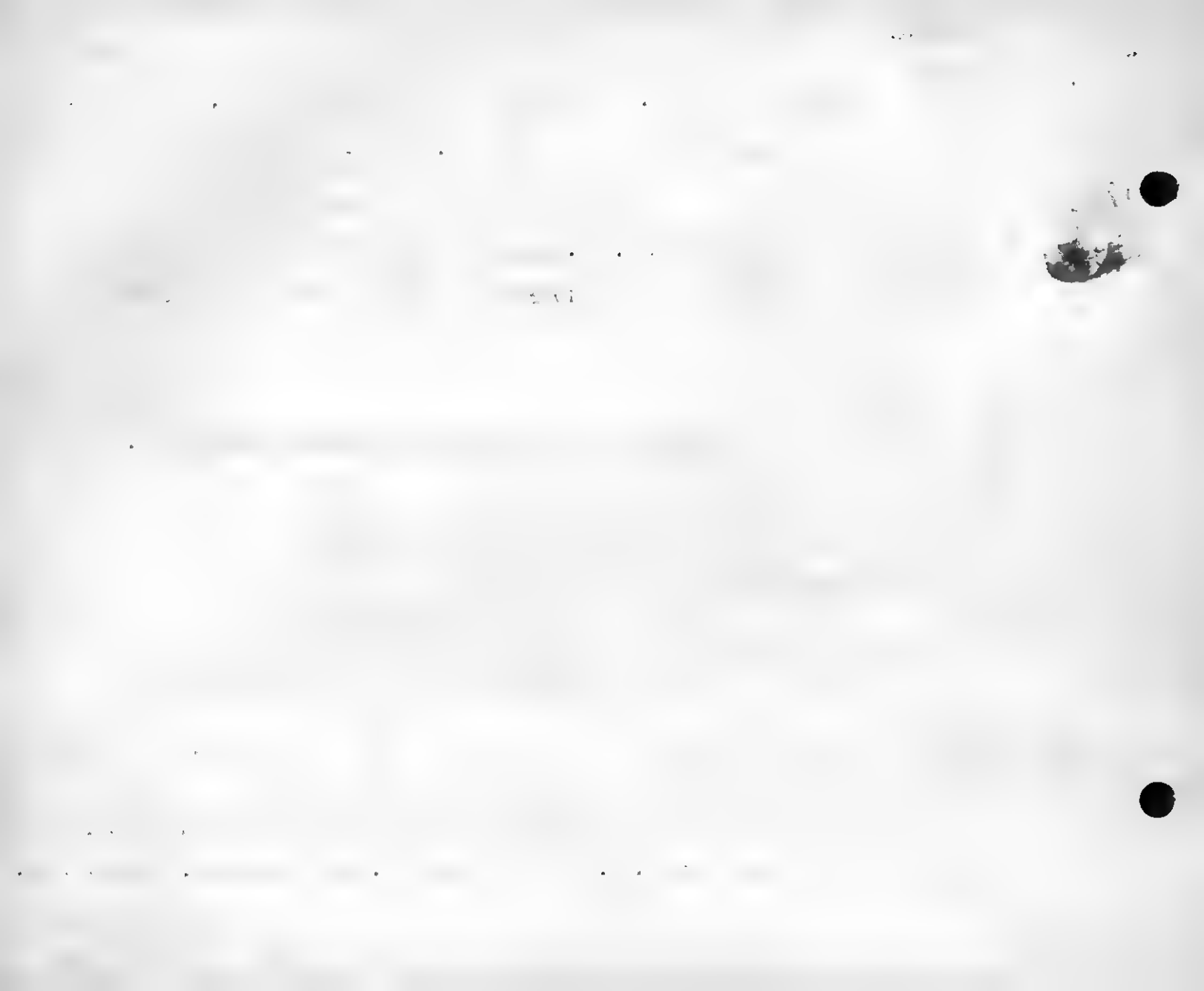
1

10044

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12052

| | | | | | |
|---|-----------------------------|--|---|---|---|
| 1. DECEASED-NAME (Type or print) Joseph W. Winter | | | 2a. DATE OF DEATH Month August Day 25 Year 1968 | | 2b. HOUR 2:30 P M |
| 3. SEX Male | 4. RACE Caucasian | 5. DATE OF BIRTH Feb. 9, 1912 | | 6. AGE (In years last birthday) 56 YRS. | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (State or foreign country) WASHINGTON, D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George's Md |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) LITHOGRAPHER | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland | | 13b. COUNTY Prince George's | 13c. CITY OR TOWN Riverdale | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 4704 Oliver Street |
| 14. FATHER'S NAME First Middle Last Unknown | | | 15. MOTHER'S MAIDEN NAME First Middle Last Unknown | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO | | 16b. SOCIAL SECURITY NO 578-053972 | | 17. INFORMANT RICHARD T. WINTER Address 5007 Oakmont St. Oxon Hill Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bronchiogenic Carcinoma with widespread metastasis. 1001 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 16-21 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic Alcoholism | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No City or Town County State | |
| 22a. I certify that he (this hospital) attended the deceased from July 17, 1968 , to August 25, 1968 , that he (we) lost the deceased alive on August 25, 1968 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above, it (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Iradj Sadeghian | | | | 22c. DATE SIGNED August 27, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) Iradj Sadeghian, M. D. | | | | 22e. ADDRESS Prince Geo. Gen'l Hospital, Cheverly, Md. | |
| 23a. BURIAL CREMATION REMOVAL (Specify) BURIAL | | 23b. DATE 8-28-1968 | | 23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEM | |
| 23d. LOCATION (City or Town) (County) (State) COLMAR MANOR, MD | | 24. FUNERAL DIRECTOR W.W. Chambers Co. Riverdale Md | | 25a. REC'D BY REGISTRAR SEP 3 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12044 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12053

| | | | | | | | | |
|---|--------------|---|--|---|---|---|--|---|
| 1. DECEASED-NAME (Type or Print) | | | 2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8 8 1968 | | | 2b. HOUR 8:15 am | | |
| James Clifton Wright | | | | | | | | |
| 3. SEX M | 4. RACE W | 5. DATE OF BIRTH 30 June 1923 | 6. AGE (In years last birthday) 45 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN | 2c. DATE PRONOUNCED DEAD Month 8 Day 8 Year 1968 | | |
| 7a. BIRTHPLACE (State or foreign country) MASS | | 7b. CITIZEN OF WHAT COUNTRY? U S A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Prince George Md. | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George H osp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) GEOLOGIST | | 12b. KIND OF BUSINESS OR INDUSTRY GOVT | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Virginia | | 13b. COUNTY Fairfax | | 13c. CITY OR TOWN Alexandria | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 615 South Fairfax |
| 14. FATHER'S NAME First Middle Last FRANK S WRIGHT | | | 15. MOTHER'S MAIDEN NAME First Middle Last CATHERINE S HOLT | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT ADDRESS WILNA B WRIGHT 615 SO FAIRFAX | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral hemothorax</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Multiple rib fractures</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Trauma-auto accident</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>8/16/68</u> | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:05am 8 8 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Driver of car involved in collision. | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Baltimore Wash., Parkway | | 21f. LOCATION Street or R.F.D. No. Bladensburg | | City or Town Prince George Md. | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) | | | 22b. DATE SIGNED 8-9-68 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | | 23b. DATE Aug. 10-68 | | 23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory | | 23d. LOCATION (City or Town) (County) (State) 300 4th St. N.E. Wash, D.C. | | |
| 24. FUNERAL DIRECTOR St. St. Delmar Jr. | | | | ADDRESS Alex. Va. 22314 | | 25a. REC'D BY REGISTRAR DATE AUG 13 1968 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge |

FOR STATE
HEALTH DEPT.

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| 12045 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 12054 | | |
|--|--|-----------------------------|---|---|--|---|--|---|--|---|--|--|
| 12045 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) First Middle Last Pearl Vita Zuckerman | | | | | | 2a. DATE KNOWN OF DEATH Month Day Year 8-20-68 | | | 2b. HOUR 19 9:04 pm | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH 2-10-1915 | | 6. AGE (In years last birthday) 53 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Russia | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Prince George's | | | |
| 10. CITY OR TOWN OF DEATH Cheverly | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY ----- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Mass. | | | | 13b. COUNTY Middlesex | | 13c. CITY OR TOWN Everett | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 80 Chatham Road | | |
| 14. FATHER'S NAME First Middle Last Harry Liberman | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Lifshe ? ? | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) Unknown | | 17. INFORMANT Meyer Zuckerman | | | ADDRESS Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LACERATION OF BRAIN 8147 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) SKULL FRACTURE DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19N | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 8124 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 9:02pm 8-20- 19 68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Pedestrian struck by car. | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. 450, Capitol Plaza | | 21f. LOCATION Street or R.F.D., No. City or Town County State Hyattsville, Prince George Co., Md. | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE John Kehoe MD | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED 8-21-68 | | | | |
| EXAMINER'S NAME (Type) John Kehoe MD | | | | ADDRESS Riverdale, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 8-23-68 | | 23c. NAME OF CEMETERY OR CREMATORY Cem. Tifereth Israel of Everett | | | | 23d. LOCATION (City or Town) (County) (State) Everett Mass | | | | |
| 24. FUNERAL DIRECTOR Goldberg Funeral Home | | | | | | ADDRESS 4217 9th St., N.W. | | | 25a. REC'D BY REGISTRAR DATE AUG 26 1968 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | |

17024

